FINAL REPORT OF THE LONG TERM CARE TASK FORCE OF THE HAMILTON-WENTWORTH DISTRICT HEALTH COUNCIL

February, 1982

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Mrs. S. Friend

Chapter I

INTRODUCTION

1. The Long Term Care Task Force:

In order to determine how this district's long term care services are meeting the needs of the residents of Hamilton-Wentworth at present and will continue to meet the needs in the future, the District Health Council on March 26, 1979 established a Task Force to study the long term care sector of the health care delivery system. In establishing the Task Force, the Health Council wanted a mix of membership which would provide input from most sectors of the community involved with long term care delivery. For this reason, the Task Force members are all professionals in the social and health care fields, enabling them to both evaluate the information they received in a knowledgeable manner, and to provide input from their own professional experience in working with clients of the long term care system. The Task of the study group was specifically defined by the terms of reference shown in Figure 1.

2. Planning Process:

The Long Term Care Task Force began its deliberations in the summer of 1979 and proceeded with the development of a planning process and the gathering of information relating to that process as briefly outlined below.

Definition:

For the purpose of this study the scope of long term care is defined as the health care which is required by individuals over a long period of time (greater than 60 days) in either an institution or the community. The study examines the long term health care services required by individuals in all age categories and follows the Ministry of Health classification of types of patient care (see Chapter 5).

Figure 1

TERMS OF REFERENCE

1. Compile an inventory of the complete range of long term care services available to the residents of Hamilton-Wentworth.

2. Review all services and determine problems associated with the provision of long term care from:

   (a) statistical information available on utilization rates, waiting lists, etc.

   (b) presentations from and discussions with persons involved in the long term health care system.

   (c) the knowledge and expertise of members of the committee and staff.

3. Determine the extent of projected demographic changes in Hamilton-Wentworth.

4. From the above information develop recommendations for presentation to the Health Council on:

I. SHORT TERM

   (a) What additional programmes and/or resources are required to effectively and efficiently provide long term care at present.

   (b) What changes in local and/or provincial procedures and regulations are required to allow the system to maintain optimum operation with the resources which are available.

II. LONG TERM

   (a) What changes of local and provincial policies and/or addition of resources will be required for the long term care system to operate effectively and efficiently over the next ten to fifteen years.

2. Planning Process - Continued

Problem Statement:

The general problem statement to which the Task Force addressed its deliberations is as follows: what long term care services/resources are required to adequately serve the Hamilton-Wentworth population?

Goal and Objectives:

In addressing this problem, the Final Report of the Long Term Care Task Force has as its goal to provide a basis on which the optimum delivery of adequate long term care services/resources for the Hamilton-Wentworth population can be planned, both now and in the future. To meet this goal, the Report also has the following objectives:

1. to describe the current long term care service resources, the population which uses these resources, and the utilization of these resources;
2. to identify gaps in the resources and the unmet needs of the population;
3. to examine the adequacy of current long term care services in the light of Ministry guidelines, and in the light of the accessibility of, and demand on, long term care resources.

Inventory of Resources:

As one of its initial steps, the Task Force undertook the compilation of a detailed inventory of long term care services in Hamilton-Wentworth. The inventory was developed with several objectives in mind. First, and most important, the Task Force realizes that in order to determine what additional services are required by a community, it is necessary to be aware of and fully understand the scope of the services already present. Second, the inventory was designed to give readers of the report an appreciation of the system which is being studied and is to be used as a resource document by the community and by the Health Council (see Appendix A).

2. Planning Process - Continued

Delineation of Areas of Inquiry:

While the Task Force was compiling the comprehensive inventory of long term care services in the Region, it was also delineating the areas of inquiry for the study. The Final Report specifies the needs of the population groups using long term care services, including the elderly, the confused ambulant, the young extended care patient, the severely retarded and the physically disabled adult, and the chronic life support patient. In addition to institutional services the report also addresses community support services, including day programming, transportation, senior citizen housing and care in the home. Other issues were raised and discussed by the Task Force and are noted in the appropriate section of the report.

Selective Literature Search:

The Task Force's investigation of the literature included a review of long term care studies conducted in Ontario and elsewhere, Ministry of Health policies relating to long term bed guideline formulae, general health care research publications, and studies relating to specific areas of concern to the Task Force (see References).

Data Collection:

In order to research this topic, the Task Force received presentations and material from a number of sources. In-person briefs were received from the Ontario Nursing Home Association, Homes for the Aged in Hamilton-Wentworth, the chronic care institutions in the district, the Hamilton-Wentworth Home Care Programme and the Health Professions Coordination Group of the Hamilton-Wentworth District Health Council. Presentations were made to the Task Force by Ministry of Health personnel and local experts in the areas of day programming, services for the confused ambulant, Senior Citizen's housing, and research methodologies (see References).

Demographic information for Hamilton-Wentworth was obtained from the Regional Municipality Planning Department for selected years up to 1980, and from the Ministry of Health for 1981 to 1991. Any calculations

2. Planning Process - Continued

involving projected populations are based on Ministry of Treasury and Economics figures.

In addition to the information received in compiling the Inventory of Resources, statistical information was received from agencies and organizations in the Hamilton-Wentworth District, including local long term care day programmes, agencies offering care in the home, transportation, and senior citizen's housing.

Considerable information was reviewed from the records of the Assessment and Placement Service which was established in 1971. The Assessment and Placement Service assists health professionals in identifying and recording the care needs of their patients so that appropriate services and placement locations can be found. The use of a standard assessment process allows for categorization of individuals according to the type of care needed so each can be referred to the appropriate facility. Further detail of the above mentioned data sources is included in Chapter 3 of the report (p.20).

Interim Report:

It became apparent as the deliberations advanced that the task associated with fulfilling the mandate as specified in the terms of reference would be a very time-consuming endeavour and could not be achieved within the time frame originally envisioned.

At the same time, constraints in the active treatment sector were causing mounting pressure on the long term care segments of the health care system. As a result, the Health Council and the Task Force agreed that to ensure resources were committed to this district within the near future, an interim report would be produced dealing solely with the needs and resource requirements in the more traditional modes of long term care, i.e., chronic care and extended health care.

Such a report was submitted to the Ministry in August, 1980, with the Task Force's comprehensive inventory appended. While it was necessary to focus on the immediate need for additional resources for extended health and chronic care in the interim report, this final report represents a more

complete examination of the District's long term care system as a whole.

Data Analysis and Interpretation:

The Task Force examined both the specific methodologies for determining the need for extended health and chronic care resources introduced in the Interim Report and other methods of identifying needs and gaps in these and other long term care services. In this way a synthesis of all information and methods allows for a more complete assessment of how the needs of the population are being met. From the analysis and interpretation of the data synthesized by the Task Force, certain specific problems relating to gaps in resources and unmet needs were identified. Further detail is included in Chapters 4 and 5 of the report.

Formulation of Recommendations:

Having examined these specific problems in light of the overall goal and objectives of the report, the Task Force reviewed alternative courses of action and recommended ways of dealing with the problems identified.

3. General Comments:

In approaching this task, the Task Force members shared several broad concerns relating to the provision of long term care services. The first of these is the recognition of the many various factors influencing the health and well-being of the elderly. This is perhaps best exemplified by the "Twelve Gerontological Principles" put forward by the Ontario Council of Health (Figure 2). These principles reflect the views of the Task Force on the importance of community support services, financial support, and the prevention of illness for the elderly and the total long term care population.

The Task Force agrees with the Ontario Council of Health that the health care needs of the elderly do not necessarily fit into the patterns of governmental organization in Ontario (Ontario Council of Health, 1978). The health and social needs of the long term care population make it imperative that the Provincial Government establish a coordinated mechanism

Figure 2

TWELVE GERONTOLOGICAL PRINCIPLES

1. The elderly are a heterogenous group with a variety of lifestyles and needs. They differ from one another more than they do from the young and even more than the young do from each other.

2. As far as possible elderly people should have a choice of determining their living arrangements as they grow older. They should be afforded an opportunity to plan ahead, with the assistance of adequate counselling for those periods in life when major change may be required.

3. The great majority of older people are relatively healthy and are living at home. Most of them are not disabled, dependent nor depressed.

4. Most older people have the desire and the potential to be productive, contributing members of society.

5. Human potential is not necessarily related to chronological age but much more related to such things as income, occupation, education and health.

6. There are different needs for health and social services between the "young-old" and the "old-old" and between elderly men and women.

7. Prevention of illnesses and accidents is always preferable to treatment and rehabilitation. It is not too late to begin to practice good health habits after the age of 65.

8. Most older people would prefer to be independent and to live in their own homes as long as possible.

9. Relocation of the elderly should be considered only when necessary and desirable and if required should be accompanied by social and psychological counselling and support.

10. Family support, accommodation and socio-economic factors are more important than health services in keeping the elderly independent.

11. Most older people feel that their condition in life is better than the greater public believes it to be.

12. Older people should always be given the opportunity of participating in decisions affecting themselves.

Source: Ontario Council of Health, Health Care for the Aged, Toronto: Ontario Council of Health, 1978.

3. General Comments - Continued

that will ensure that these needs are met. Several specific issues are raised in the body of the report to which the Task Force has recommended that the Ministry of Health initiate discussions with other Ministries, with a view to alleviating the specific problems. Other issues are raised which the Task Force feels are outside of its purview in making recommendations. These issues are discussed in the body of the report and the comments directed towards governmental bodies and organizations other than the Ministry of Health (eg. Services for the Aged Sub-Committee of the Regional Social Services Department). More generally, though, the Task Force wishes to urge the Provincial Government to examine ways in which the provision of long term care services may be made more flexible, both in terms of resources and jurisdictions. Divided jurisdiction usually means lack of coordination and lack of planning.

This is not a new concern by any means. When the Committee on Health Care for the Aged of the Ontario Council of Health reported in 1978, it recommended that the various Ministries involved in long term care set up appropriate inter-ministerial structures to enhance planning and allow more flexibility in the provision of long term care. However, as a noted social policy analyst has recently remarked, there is little evidence that this recommendation has been implemented (Rose, 1981).

The Task Force wishes to acknowledge a recent example of inter-ministerial cooperation in the joint announcement by Dennis Timbrell, Minister of Health and Frank Drea, Ministry of Community and Social Services, made in October, 1981, regarding an expansion of homemaker services. In his announcement, Mr. Timbrell noted that the Ministry of Health is placing a greater emphasis on improving the availability and accessibility of community resources to help people who require some assistance to remain in their homes. The Task Force supports this statement and adds that long term care involves much more than the provision of beds. Consequently, the philosophy which underlies the provision of long term care must be more than an acute care philosophy applied to care given over a long period of time. Issues such as quality of life must be considered in long term care, other than the mere provision of a bed and basic care. Hence, the Task Force wishes to stress the importance of programmes as well as beds in the institutional setting, and of community-based support services.

3. General Comments - Continued

The Final Report is intended to provide a basis on which the optimum delivery of adequate long term care service resources for the Hamilton-Wentworth population might be planned, both now and in the future. It is a resource document for the Hamilton-Wentworth District Health Council, indicating needs and priorities for action. It is also a report to the Ministry of Health, advising the Minister on how local long term care needs might best be met. The Long term care situation is one which is continually changing. While this report is intended as a basis for future coordination and action, it is recognized that this planning must be both flexible and innovative in its response to uncertain future conditions.

The second chapter presents the recommendations of the report, each being preceded by a brief summary of the rationale behind the recommendation. Chapter 3 presents an overview of the long term care system in Hamilton-Wentworth, looking at population projections, current resources and resource utilization.

This is followed in Chapter 4 and 5 by an in-depth examination of the provision of community-based long term care services and institutional-based long term care services. The discussion of individual services in these chapters includes the presentation of definitions, background material explaining the issues involved in the provision of the service, an inventory of the service availability in the Region and, where applicable, information pertaining to accessibility, Ministry guidelines and waiting lists. This information is then compiled in a summation where the specific conclusions and recommendations of the Task Force are presented.

Chapter 2

SUMMARY OF RECOMMENDATIONS

The following recommendations as listed do not necessarily reflect the order of importance.

Day Programming:

Under current funding arrangements, the operating budgets of both the St. Peter's Day Therapy programme and the Chedoke Continuing Care Centre Day Hospital programme are provided in part from the institutions' internal global budgets. The Task Force notes that the District Health Council supported requests from these institutions in 1979 for additional Ministry of Health funding. Response to these requests was deferred by the Minister pending the Task Force's final report, which has documented that, without this funding, both programmes may be cut back by the administering institutions when they should be expanding to meet identified needs in the community.

Recommendation 1:

> The Task Force recommends that the Ministry of Health provide additional funding to the St. Peter's Centre Day Therapy programme and to the Chedoke Continuing Care Centre Day Hospital programme in order to allow for a sound base for current operations and the provision for needed future expansion.

In addition, the Task Force is concerned about the accessibility of day programmes to residents of the east end of the Region who are limited to the availability of the day programme at St. Peter's Centre. Accessibility to this programme, however, is hampered by distance and transportation problems. The Task Force feels that a separate day programme is necessary to serve the over 6,000 elderly who live in the East End, and this is supported by a recommendation of the East End Community Health Services

Facility Task Force of the Health Council to establish a geriatric day therapy centre in the proposed East End facility.

Recommendation 2:

> The Task Force recommends the establishment of a day therapy programme for the frail and handicapped elderly in the East End of Hamilton-Wentworth in conjunction with the development of the East End Community Health Services Facility.

Transportation:

The Disabled and Aged Regional Transit System (D.A.R.T.S.) provided approximately 98% of all transportation that was provided for long term care clients unable to use the regular transit system in 1980-81. The priorities set by the Ministry of Transportation and Communications for the service are work, education, medical and recreation, in that order. Within these priorities, trips for medical and other health related purposes cannot currently be made in the early morning or late afternoon. This has implications for all long term health services, but particularly for day programmes that are dependent on D.A.R.T.S. to transport their clients daily. The Task Force notes that unless D.A.R.T.S. is adequately subsidized, it will not be able to expand to meet all of the long term care transportation needs in the Region.

Recommendation 3:

> The Task Force recommends that the Ministry of Health, through discussions with the Ministry of Transportation and Communications, examine the issue of low priority and resulting restricted availability of D.A.R.T.S. transportation for health purposes, and the issue of adequate subsidization of D.A.R.T.S. to enable it to

expand to meet all of the long term care transportation needs in the Region.

With the establishment of other transportation services, such as the Home Care Programme's Friendly Visitor and Family Support Programme, the potential for problems relating to a lack of communication and coordination increases. Coordination of these services would allow an increased awareness of their existence on the part of agencies and potential clients in the community, and would reduce unnecessary mileage in their transportation.

Recommendation 4:

The Task Force recommends that the Health Council, in cooperation with those involved in long term care transportation, work towards the Region-wide coordination of this service.

Senior Citizen Housing:

As aging proceeds and health problems become more frequent, the provision of alternatives to continued residence in one's own accommodation may help to alleviate the pressure on health care services. Insufficient alternatives lead to problems in the transition from self-care to assisted care, which often involves a shift in Ministerial responsibility from Housing to Health. Both health and social support services provided in conjunction with senior citizen housing and available community services are required, as are improved mechanisms for transfer to alternative care.

Recommendation 5:

The Task Force recommends that the Health Council, in conjunction with the Public Health Unit, initiate discussions with the Hamilton-Wentworth Housing Authority to facilitate the establishment of warden systems, meals services and space for

public health services in senior citizen residences; and to plan adequate mechanisms for transfer to alternative types of care when a resident is no longer able to manage the activities of daily living with available home support services.

Care in the Home:

(a) The Home Care Programme:

Recognizing the importance of homemaker services in assisting those who need help to stay in their homes as long as possible, the Task Force feels that access to homemaker services would be greatly improved if they were available under the Home Care Programme to all who need them. Currently this is not the case and statistics from 1980-81 show that almost 800 referrals to the Home Care Programme were refused because they did not require professional services, whether or not homemaker services were also needed. At the same time, the Task Force notes the proposed expansion of homemaker services announced jointly by Dennis Timbrell, Minister of Health and Frank Drea, Minister of Community and Social Services in October 1981, and anticipates further announcements which will specify the exact nature of the proposed expansion. In the meantime, the Task Force makes the following recommendation.

Recommendation 6:

The Task Force recommends that the Ministry of Health expand the eligibility criteria for the Home Care Programme to allow access for those who require only homemaker services.

(b) Respite Care in the Home:

Respite care in the home is usually available to some clients of the Home Care Programme and to cancer patients. Its availability to the remainder of

the long term care population, however, appears limited to that provided by the Regional Social Services Department's Attendant Companion programme, which is a relatively new service.

Recommendation 7:

> The Task Force recommends that the Services for the Aged Subcommittee of the Regional Social Services Department, in conjunction with the Assessment and Placement Service, monitor the provision of respite care in the home with a view to identifying unmet need.

Residential Care:

The Task Force notes that each home for the aged maintains its own waiting list, and that these lists are neither mutually exclusive nor centrally coordinated. A central coordination of these lists, through the Assessment and Placement Service, would further assist the coordination of placements to these beds and would facilitate the use of waiting lists as a planning tool, similar to the way in which waiting lists for other institutions are used.

Recommendation 8:

> The Task Force recommends that the Assessment and Placement Service, in cooperation with homes for the aged in the Region and Ministry of Community and Social Services (COMSOC), work towards the centralization of waiting lists for residential care in homes for the aged, to assist the further coordination of placements to residential care beds in homes for the aged, and to allow the use of these waiting lists for planning purposes.

Extended Care:

Hamilton-Wentworth, with 1,515 extended care beds in 1980-81, was 95 beds short of the Ministry minimum guidelines for 1981. With the addition of 55 beds in 1981-82 the Region will continue to be below this minimum guideline for extended care beds. If the average waiting time for extended care beds is to be gradually reduced to more closely approximate the provincial average determined by those areas participating in the Placement and Support Services (P.A.S.S.) Information System, 187 additional extended care beds will be required.

With the projected increases in the number of elderly, both in absolute numbers and in percentage of the total population, there is little doubt that Hamilton-Wentworth will need additional extended care beds by 1986, and that the figure of 187 is conservative; nevertheless, this number will be evaluated based on the impact to the system of the 83 beds coming on stream between 1981 and 1983. It is felt that 9-12 months is necessary for the system to reach a steady state after the addition of large numbers of new beds.

Recommendation 9:

> The Task Force recommends that 187 extended care beds be approved to be phased into the Hamilton-Wentworth extended care system between 1983 and 1986 to bring the total extended care beds to 1,818.

Chronic Care:

At the time of the Task Force's Interim Report, there were 393 chronic care beds on stream, and a further 75 had been approved by the Minister and have subsequently been brought on stream. In May, 1981, in response to the Task Force's Interim Report, the Minister approved in principle an additional 60 beds and suggested that a further 127 beds recommended by the Task Force be planned in conjunction with the proposed redevelopment of the Chedoke Division of Chedoke-McMaster Hospital.

A comparative analysis of the average length of wait for placement in Hamilton-Wentworth in 1980-81 with that of all other areas of the Province participating in the P.A.S.S. Information System indicates that 76 chronic care beds, beyond the number recommended in the Interim Report, are required to bring the average length of wait in Hamilton-Wentworth into equity with the P.A.S.S. Information System. This would bring the Regional total to 731 beds, and the new beds would be phased in concurrent with the redevelopment of the Chedoke Division of Chedoke-McMaster Hospital. The Ministry of Health minimum guideline for chronic care beds identifies minimum bed requirements for this Region of 583 in 1981 and 653 in 1986. This guideline is based on referral population projections which are not available beyond 1986. These figures lend support to those recommended in the Interim Report, suggesting that additional beds be phased in over the next several years, with a long range goal of 731 chronic beds by 1990-91.

In addressing the present short term need for additional beds, the Minister approved 60 beds in May 1981. At this time, however, the availability of beds and space will dictate the location of these beds. The Task Force recommends that the immediate addition of these beds take place where facilities exist, until the facilities at Chedoke Division are redeveloped.

Recommendation 10:

The Task Force recommends that the total number of chronic care beds in the Region be 731 by 1990-91, to be distributed as follows:

-St. Peter's Centre	284		-current # beds
-St. Joseph's Hospital	30		-current # beds
-Chedoke Division of Chedoke-McMaster Hospital	417:	120	-current # beds
		35	-from McMaster Division
		60	-approved, May, 1981
		127	-additional beds required, 1986
		75	-additional beds required, 1990
		417	
	731		

and further, that, of the 60 beds approved in May, 1981, 38 be temporarily located at Henderson General Hospital awaiting the re-development of the Chedoke Division of Chedoke-McMaster Hospital, consisting of:

30 - general maintenance beds
8 - life support beds
38

Other Institutional Care:

(a) Extended Care for the Non-Elderly:

The non-elderly segment of the extended care population currently occupies approximately 6% of the extended care beds in the Region and has accounted for 6% to 9% of Assessment and Placement Service placements to those beds in the past three years (see Table 20). Because of their age, placement in a nursing home may leave the psycho-social needs of this group unmet.

In addition, the Administrator of the Assessment and Placement Service has noted that many in this category refuse placement to a nursing home, thus creating difficulty for Assessment and Placement Service staff in securing placement to a treatment setting in which their needs will be met.

Recommendation 11:

The Task Force recommends that the Health Council, in conjunction with the Assessment and Placement Service, undertake further study of the need for developing appropriate programmes/facilities for extended care patients under age 65.

(b) Chronic Life Support:

Chronic life support patients require expensive life support mechanisms and/or extensive nursing services. This group is generally cared for in an acute setting despite its long term chronic nature, as the services required are either not normally available in chronic care facilities or are greatly in excess of normal staffing patterns. From October 1980 to September 1981, the Assessment and Placement Service recorded an average of four persons at any one time for whom this type of care was required, with a maximum of eight at any one time.

Recommendation 12:

> The Task Force recommends that, together with the 30 general maintenance chronic beds being recommended for temporary location at the Henderson General Hospital, 8 beds designated for chronic life support be set up at the same location.

(c) Physically Disabled and Profoundly Mentally Retarded Young Adults:

The Assessment and Placement Service has identified 20 physically disabled and profoundly retarded young adults for whom there appears to be no suitable placement location. The current inappropriate placement of this group is preventing the admission of suitable referrals to this home. Before appropriate placement can be made, however, the question of Ministerial responsibility in this specific case must be dealt with.

Recommendation 13:

> The Task Force recommends that the Health Council initiate discussions through the Ministry of Health, with the Ministry of Community and Social Services (COMSOC) and the Rygiel Home, with a view to

resolving the issue of appropriate placement for those residents of this home over age 18 who are both physically disabled and profoundly mentally retarded.

(d) Confused Ambulant:

In Hamilton-Wentworth, as is the case elsewhere, there exists an identifiable sub-group of the long term care population who, because they are confused and ambulant, require a great deal of care and supervision. Early detection and treatment can potentially result in the reversal of this condition through the services of geriatric psychiatry. For others, the quality of life may be improved and the level of required care reduced. There will still remain, however, a large portion of this group who will require placement to long term care services with appropriate facilities and programming. The availability of such facilities and programming will be monitored by the Health Council and the Assessment and Placement Service, to ensure that sufficient services are available.

Currently in the Region there are limited geriatric psychiatry services, and the extent of their potential impact on institutionalization rates for this group is not fully known. The Task Force recognizes the accomplishments of the Geriatric Psychiatry Assessment and Consultation Service located at the Chedoke Division of the Chedoke-McMaster Hospital in diagnostic assessment, rehabilitation and liaison with community agencies, and makes the following recommendation.

Recommendation 14:

The Task Force recommends that Chedoke-McMaster Hospital, in its feasibility study of the rebuilding of the Chedoke Division, determine the appropriate size and scope of the Geriatric Psychiatry Assessment and Consultation Service to meet District needs.

Chapter 3

LONG TERM CARE IN HAMILTON-WENTWORTH: AN OVERVIEW

1. The Regional Municipality of Hamilton-Wentworth:

The Regional Municipality of Hamilton-Wentworth is shown in Map 1. Within the geographic area of 428 square miles, 74.8% of the population at year end 1980, lived in the City of Hamilton. The towns of Stoney Creek, Ancaster and Dundas accounted for a further 17.0% of the population, while the remaining 8.2% were distributed in the largely rural townships of Flamborough and Glanbrook.

Table 1 summarizes the population of the Region, showing geographic distribution at year end for the years 1976, 1978 and 1980 (as reported by the Regional Municipality of Hamilton-Wentworth, Planning and Development Department) and showing projected total populations for 1981, 1986, 1991 and 1996 (from the Ministry of Treasury and Economics). The Regional population peaked in 1977 at 411,358. Within the Region, the population of Hamilton City has declined since 1976, while the other area municipalities have remained relatively stable, or increased in population.

2. The Long Term Care Population in Hamilton-Wentworth:

Tables 2 to 4 describe the elderly, who comprise the major group using long term care services. Table 2 shows the geographic distribution of the elderly population in the Region over the past few years. It is worthwhile noting that, while the proportionate distribution of elderly across the Region has remained fairly stable, both the number and proportion of elderly in each area municipality and in the Region as a whole have increased.

Table 3 shows the projected elderly population in the Region for 1981 to 1996. It is interesting to note that while the projected populations for the Region may be high, the percent of population over age 65 in 1980 (11.1% from Table 2) was almost as high as that projected by the Ministry of Health for the Region for 1986 (11.8% from Table 3).

Thus, it appears that while the general population is not increasing as rapidly as projected, the proportion of elderly is exceeding projections.

Table 4 shows the age distribution of the elderly in the Region. It is noted that the Treasury and Economics projections identify a bulge in the age 65-69 group in 1991, which is transferred to the age 70-74 group in 1996 and, although not shown on this table, will be transferred to the over age 75 group by 2001. In 1980, 39.2% of the elderly were over age 75. By 1996, 41.0% will be in this age group. It is also noted that the actual 1980 populations in the 70-74 and 75-79 age groups exceed the Ministry of Treasury and Economics projections for 1981.

Table 5 shows that 86.4% of those referred to the Assessment and Placement Service for placement to a long term care service in 1980-81 were over the age of 65. While the largest portion of the elderly population is under age 75 (60.8% in 1980 from Table 4), the majority of Assessment and Placement Service users are over that age (76.3% in 1980-81 from Table 5). This supports other data which shows that the majority of long term care services, particularly institutional services, are used by the group over age 75.

These figures describing the long term care service population take on greater significance when set into the context of Provincial and National trends in health care utilization. In Ontario, 9% of the population was over age 65 in 1976 and this is projected to increase to 12% by 1991. In 1976, the population over the age of 65 (9%) accounted for 17% of O.H.I.P. payments to practitioners; 33% of active treatment bed utilization; 74% of chronic bed utilization; and 93% of extended care bed utilization (Provincial Secretary for Social Development, 1980).

Across Canada, 8.7% of the population was over the age of 65 in 1976 and this is projected to increase to 11.1% in 1991 and to 20.2% by the year 2031. In 1975, the Canadian population over the age of 65 accounted for 37.8% of the total patient days of public general hospitals and allied special hospitals across the country. The average length of stay in those

hospitals in 1976 was 20.4 days for the elderly population compared to 7.4 days for the rest of the population (Angus, 1980).

3. Long Term Care Service Resources in Hamilton-Wentworth:

The Task Force completed a comprehensive inventory of long term care services in the Hamilton-Wentworth Region, including institutions, residences, community-delivered services, child and adolescent services, and recreational services for the Interim Report. This inventory has been updated and is attached as Appendix A.

Table 6 summarizes the distribution of long term care beds and their relationship to the elderly population in the Region on March 31, 1981. Since then, 40 more chronic beds have come on stream, and another 60 have been approved in principle by the Minister of Health. Also, the Minister recently announced a shifting of 39 nursing home beds from Hamilton to Stoney Creek coupled with the addition of 61 new beds in Stoney Creek, the addition of 22 new beds in Hamilton and the permanent licensing of 17 previously temporary beds. These new beds will not all be on stream until 1983-84.

Over 80% of the Region's elderly live in Hamilton and, accordingly, over 77% of the Region's long term care beds are located there. Dundas, with under 6% of the elderly, has over 19% of the Region's long term care beds. The remaining beds are located in Stoney Creek, with none located in Flamborough, Ancaster or Glanbrook.

4. Utilization of Long Term Care Services in Hamilton-Wentworth:

Table 7 shows the number and age of placements made through the Assessment and Placement Service to long term care services in 1980-81. Of the total of 1,074 placements, 925 (86.1%) were age 65 or over and 149 (13.9%) were under age 65. Looking only at the 817 placements made to residential, extended and chronic beds in the Region, it is noted that 740 (90.6%) were elderly persons. The Chedoke Continuing Care Centre Day Hospital programme accepts only non-elderly long term care patients.

On December 31, 1979, 72,288 elderly persons were residents in institutions across the Province, representing 8.9% of the total elderly population. On the same date in Hamilton-Wentworth, there were 3,170 elderly persons, representing 7.4% of the Regional elderly population, residing in institutional facilities (Ministry of Health, December, 1981).

Table 8 provides details regarding the location at time of referral of the 2,199 people referred to the Assessment and Placement Service during 1980-81. Of these referrals, 11.1% were from outside the Hamilton-Wentworth Region. Of those from Hamilton-Wentworth, 42.2% waited in hospitals and 57.8% waited in the community.

Table 9 shows the optimal placement recommendation and the actual placement outcome for the 1,074 cases placed through the Assessment and Placement Service in 1980-81. Of those for whom the optimal placement recommendation made by Assessment and Placement Service was residential care, 71.2% were placed in residential care; 16.3% were placed in extended care; and 6.5% were placed with the Home Care Programme. Over 76% of those for whom the optimal placement recommendation was extended care were placed in extended care; another 10.8% were placed in residential care and 7.4% were placed with the Home Care Programme. Where Assessment and Placement Service optimally recommended chronic care, it was received in 90.7% of cases, with a further 4.7% receiving extended care.

Table 10 shows the average length of wait for placement through Assessment and Placement Service to long term care facilities in the Region over the past three years. In reading this table, it should be noted that not all placements made to residential care in homes for the aged are made through Assessment and Placement Service and that Assessment and Placement Service does not make placements to lodging homes. Rather, clients for whom residential care in a lodging home is recommended are so advised and make their own arrangements.

Table 11 shows the trend in numbers waiting for placement in one particular month over the past five years. It is noted that, in general, the number of people waiting in the community has increased, while the number waiting in hospital has decreased.

MAP 1: REGIONAL MUNICIPALITY OF HAMILTON-WENTWORTH

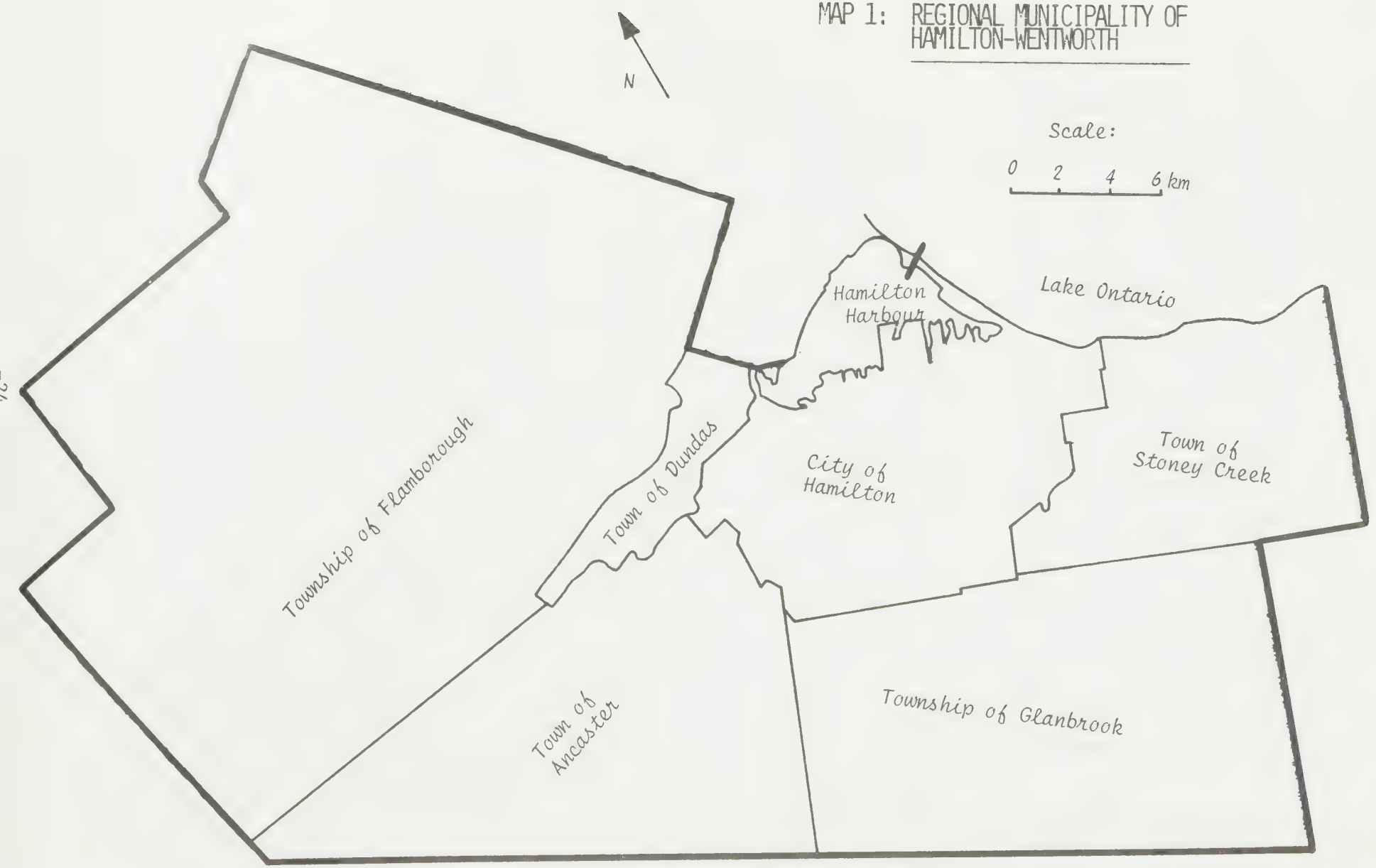

Table 1

The Population of Hamilton-Wentworth

	Hamilton-Wentworth	Hamilton	Stoney Creek	Flamborough	Dundas	Ancaster	Glanbrook
1976	409,331	312,162	30,366	23,364	19,212	14,180	10,047
1978	407,521	307,583	32,922	23,885	19,096	14,111	9,924
1980	410,503	306,853	35,877	24,184	19,507	14,361	9,721
1981	423,784						
1986	436,027						
1991	444,504						
1996	448,376						

Source: 1976-1980: Regional Municipality of Hamilton-Wentworth
Planning and Development Department

1981-1996: Ministry of Treasury and Economics

Table 2

Geographic Distribution of the Elderly
in Hamilton-Wentworth, 1976, 1978, 1980

	1976			1978			1980		
	Population ≥ Age 65	% ≥ Age 65 Population	% Total Population	Population ≥ Age 65	% ≥ Age 65 Population	% Total Population	Population ≥ Age 65	% ≥ Age 65 Population	% Total Population
Hamilton	33,433	81.7	9.9	34,393	81.0	11.2	36,620	80.6	11.9
Stoney Creek	2,128	5.2	6.5	2,346	5.5	7.1	2,608	5.7	7.3
Flamborough	1,391	3.4	5.6	1,603	3.8	6.7	1,769	3.9	7.3
Dundas	2,332	5.7	11.3	2,406	5.7	12.6	2,626	5.8	13.5
Ancaster	1,105	2.7	7.1	1,112	2.6	7.9	1,194	2.6	8.3
Glanbrook	532	1.3	4.9	585	1.4	5.9	622	1.4	6.4
Hamilton-Wentworth	40,921	100.0	10.0	42,445	100.0	10.4	45,439	100.0	11.1

Source: Regional Municipality of Hamilton-Wentworth
Planning and Development Department

Table 3

Projected Elderly Population
in Hamilton-Wentworth, 1981 to 1996

	Total Population	Population ≥ Age 65	% Total Population
1981	423,784	45,761	10.8
1986	436,027	51,401	11.8
1991	444,504	59,924	13.5
1996	448,376	64,877	14.5

Source: Ministry of Treasury and Economics

Table 4

The Elderly Population in Five Year Age Groups
in Hamilton-Wentworth

	65-69	70-74	75-79	80-84	≥85
1978	14,593	11,138	8,216	4,808	3,676
1980	15,667	11,952	8,608	5,371	3,808
1981	15,795	11,949	8,548	5,501	3,968
1986	16,892	13,652	9,673	6,265	4,919
1991	21,383	14,636	11,023	7,108	5,774
1996	19,753	18,524	11,862	8,076	6,662

Source: 1978 to 1980: Regional Municipality of Hamilton-Wentworth
Planning and Development Department

1981 to 1996: Ministry of Treasury and Economics

Table 5

Age of A.P.S.[1] Users at Time of Referral

	1978-79	1979-80	1980-81
0-4	17	---	---
5-9		1	---
10-14		3	1
15-19		7	11
20-24		4	19
25-29	14	7	13
30-34		8	13
35-39	29	6	5
40-44		11	10
45-49	58	17	19
50-54		42	50
55-59	165	39	49
60-64		104	108
Total < Age 65	283	249	298
65-69	439	118	192
70-74		193	258
75-79	745	330	376
80-84		378	480
85-89	437	295	378
90-94		129	148
95-99		40	51
100-104		9	12
Total ≥ Age 65	1,621	1,492	1,895
Missing Data	143	21	6
Total Referrals	2,047	1,762	2,199

Source: A.P.S. Annual Report, 1980-81

[1]-Assessment and Placement Service of Hamilton-Wentworth

Table 6

Long Term Care Institutional Beds
in Hamilton-Wentworth, March 31, 1981

		Residential		Extended Care				Chronic	
				Nursing Homes		Homes for the Aged			
	% ≥ Age 65 Population	# Beds[3]	% Beds	# Beds	% Beds	# Beds	% Beds	# Beds	% Beds
Hamilton	80.6	1123	72.9	934[1]	86.9	199	45.1	428	100.0
Stoney Creek	5.7	50	3.2	60[2]	5.6	---	---	---	---
Flamborough	3.9	---	---	---	---	---	---	---	---
Dundas	5.8	367	23.8	80	7.5	242	54.9	---	---
Ancaster	2.6	---	---	---	---	---	---	---	---
Glanbrook	1.4	---	---	---	---	---	---	---	---
Hamilton-Wentworth	100	1540	100	1074	100	441	100	428	100

[1]-Does not include 154 Homes for Special Care beds; includes 30 beds with a temporary license

[2]-Does not include 9 Homes for Special Care beds

[3]-Includes homes for aged and lodging homes

Table 7

Number, Age and Percent of A.P.S.[1] Placements
to Long Term Care Services
in Hamilton-Wentworth, 1980-81

	< Age 65	%	≥ Age 65	%	Total	%
Residential	18	10.5	153	89.5	171	15.9
Extended Health	29	6.2	392	93.1	421	39.2
Chronic	30	13.3	195	86.7	225	20.9
Home Care	9	14.3	54	85.7	63	5.9
C.C.C.C.[3]	15	100	---	---	15	1.4
St. Peter's Day Therapy	16	26.7	44	73.3	60	5.6
Other	32	26.9	87	73.1	119	11.1
Total	149	13.9	925	86.1	1074	100

[1]-Assessment and Placement Service of Hamilton-Wentworth

[2]-Includes homes for the aged and lodging homes

[3]-Chedoke Continuing Care Centre Day Programme

Table 8

Location at Time of Referral to A.P.S.[1]

HAMILTON-WENTWORTH	
Henderson Hospital	209
Hamilton General Hospital	161
St. Joseph's Hospital	198
*Chedoke Division	101
*McMaster Division	87
St. Peter's Hospital	24
Hamilton Psychiatric Hospital	24
Rygiel Home	20
Community	1130
HALTON	
Hospitals	125
Community	53
ONTARIO	
Hospitals	39
Community	19
CANADA	4
OUTSIDE CANADA	1
missing data:	4
TOTAL	2199

*Locations of Chedoke-McMaster Hospitals

[1]-Assessment and Placement Service of Hamilton-Wentworth

Source: Assessment and Placement Annual Report 1980-81

Table 9

Appropriateness of A.P.S.[1] Placements to Long Term Care Services in Hamilton-Wentworth, 1980-81

Optimal Placement Recommendation	Actual Placement							
	Residential[2]	Extended Health	Chronic	Home Care	C.C.C.C.[3]	St. Peter's Day Therapy	Other	Total
Residential[2]	109	25	--	10	--	1	8	153
Extended Health	54	379	2	37	--	5	21	498
Chronic	1	11	214	2	1	--	7	236
Home Care	2	--	--	9	--	--	--	11
C.C.C.C.[3]	--	1	--	--	14	--	--	15
St. Peter's Day Therapy	1	--	--	2	--	53	3	59
Other	4	5	9	3	--	1	80	102
Total	171	421	225	63	15	60	119	1074

[1]-Assessment and Placement Service of Hamilton-Wentworth

[2]-Includes homes for the aged and lodging homes

[3]-Chedoke Continuing Care Centre Day Programme

Table 10

Average Length of Wait for Placement to Long Term Care Beds
in Hamilton-Wentworth,
1978-79, 1979-80, 1980-81

	1978-79		1979-80		1980-81	
	Total Placements	Avg. Length of Wait	Total Placements	Avg. Length of Wait	Total Placements	Avg. Length of Wait
Residential[1]	187	120.6 days	164	102.3 days	171	105.0 days
Extended Health	356	108.7 days	370	132.3 days	421	89.6 days
Chronic	165	147.7 days	168	129.8 days	225	128.8 days

[1]-Includes homes for the aged and lodging homes

Source: Assessment and Placement Service Data

Table 11

Five Year Comparison of Waiting Lists
for the Month of November

In institutions awaiting placement

Facility Required	1977	1978	1979	1980	1981
Nursing Homes	157	128	141	112	73
Chronic Hospitals	88	116	95	80	88
Homes for the Aged	40	19	31	30	27
Rehabilitation Units	3	5	4	0	0
Community Services	16	16	2	10	5
Other	10	2	11	7	6
Total in hospital	314	286	284	239	199

In the community awaiting placement

Facility Required	1977	1978	1979	1980	1981
Nursing Homes	108	140	186	115	103
Chronic Hospitals	30	40	71	33	41[1]
Homes for the Aged	109	144	138	148	165
Rehabilitation Units	2	1	1	2	0
Community Services	23	41	43	31	39
Other	27	26	27	12	19
Total in community	299	392	466	341	367
Total awaiting placement	613	678	750	580	566

Source: A.P.S. 1980-81 Annual Report

[1]-17 awaiting respite care

Chapter 4

COMMUNITY-BASED LONG TERM CARE SERVICES

1. Day Programming

Definition:

(a) A Day Hospital is a place which has an organized day programme related to a hospital or other health care agency for clients requiring diagnostic, rehabilitative and/or therapeutic services during the day for some part of the week on a scheduled basis and provides health and rehabilitative services under the supervision of medical and other professional health workers and/or social workers (Ontario Ministry of Health, 1980).

(b) A Day Centre is a place which has an organized day programme for frail, moderately handicapped or slightly confused clients who require some level of care and supervision during the day for some part of the week on a scheduled basis, and provides a pleasant and safe environment and activities to promote socializing, mental stimulation and physical well-being (Ontario Ministry of Health, 1980).

Background:

Day Programmes in long term care are rapidly increasing in number in Ontario, yet there are no policy guidelines which formally differentiate between types of programmes. Hence, the Task Force noted considerable confusion associated with long term care day programming, originating with the various names associated with day programming, such as day hospital, day centre, day therapy, day care, senior's day care, senior's centre, elderly persons centre, etc. This confusion is further compounded by the amount of variation in the range of services offered and in the degree to which programmes are structured, even in programmes that have the same name or label, to the point where distinctions can be primarily administrative (Farquhar, 1980).

This examination of day programming focuses on those programmes targeted towards the frail or handicapped, and the above definitions of day hospital and day centre are an attempt by the Ministry of Health to categorize such programmes. Difficulties arise, however, in attempting to fit existing day programmes into this categorization. This is readily evidenced in Hamilton-Wentworth, where there are five such day programmes of varying sizes, three of which are funded partially by the Ministry of Community and Social Services, one by a Federal New Horizon's grant, and one funded through the global budget of a public general hospital. This latter programme has been referred to as a day hospital, but none of the other programmes refer to themselves as either a day hospital or day centre. The Task Force notes that the Ministry of Health is currently examining the issues of categorizing and providing guidelines for day programmes, particularly in the areas of funding and evaluation procedures.

Day programmes in long term care are often described as part of the total continuum of care rather than as a service isolated from other long term care needs and services. As such, the advantages of day programmes most frequently mentioned in the literature are the delay of institutional admission and the possibility of earlier discharge, resulting in a more efficient use of long term care beds. Other studies point to an improvement in quality of life, a lower death rate and potential cost savings. Further study is required, however, to evaluate and confirm these programme outcomes (Farquhar, 1980; National Centre for Health Services Research, 1980; Skellie and Coan, 1980; Rafferty, 1979; Kane and Kane, 1980).

A leading British geriatrician has suggested a need for two day hospital places and two psychogeriatric day hospital places, which provide psychiatric as well as medical services, per 1,000 population over age 65 (Brocklehurst, 1975). In the absence of provincial guidelines, it has been suggested that day programmes operate with specific objectives based on an assessment of the unmet needs of specific target populations. The utilization of such programmes can be closely monitored and programme outcomes more easily evaluated in light of the specific objectives and target

groups (Farquhar and Earle, 1979).

Inventory - Day Programmes:

There are five day programmes in long term care in Hamilton-Wentworth directed towards the frail or handicapped. For the purposes of categorization, three of these can be considered as fitting into the above definition of day centre. The other two programmes - St. Peter's Centre Day Therapy and Chedoke Continuing Care Centre - clearly provide more than what is defined as a day centre, and can be considered as fitting into the definition of day hospital. The following briefly describes each of these programmes, noting their similarities and differences.

(a) St. Peter's Centre Day Therapy Programme:

St. Peter's Centre operates a Day Therapy Programme which offers community support to elderly citizens and their families in dealing with physical, psychological and related social problems. Methods are used to assist the clients to achieve and maintain the maximum degree of independence to which they are capable within the limits of available resources. These resources include nursing, physiotherapy, occupational therapy, social work counselling, recreational activities, speech therapy, health counselling, nutritional counselling and chiropody. The Centre has a fully equipped dental room, which is currently unstaffed because appropriate personnel are unavailable.

Clients admitted to the Day Therapy Centre programme will have functional needs which may fall primarily into the following categories:

(i) Heavy Maintenance - severely disabled requiring extensive care by family and community agency.

(ii) Alert Maintenance - with severe disabilities who need activation to prevent deterioration.

(iii) Physical - including people with moderate to severe physical disabilities and possibly psychological impairment who have been unable to cope with their daily lives.

(iv) Social Isolation - Persons with relatively minor physical or psychological impairment but who have become socially withdrawn and are poorly adjusted to their environment.

(v) Awaiting Placement - where home circumstances can no longer support them and are in the process of admission to long term care.

Referrals to the programme are accepted from the Assessment and Placement Service, physicians, health and social agencies in the community, and from the client/family. The individual's physician is involved in each case through initial diagnosis and admission conference, and is kept apprised of the client's progress to assure continuity of service.

Upon admission to the programme an evaluation process is initiated including five functional assessment visits. Through these visits, the client is introduced to staff and other clients and is given assessments by a registered nurse, a social worker, and other assessments as required (e.g. occupational therapy, physiotherapy, speech therapy). During the fifth visit an admission conference is held to identify problems, initiate actions and establish goals. The conference involves a multi-disciplinary team including the clinical supervisor, registered nurse, social worker, therapists, family physician, the client and family. A time frame for review and follow-up is set and discharge plans may be initially discussed.

When clients are accepted into the programme the overall goal is to assist them in the process of assimilation back into community actitivies. This goal is further defined by the following objectives:

(1) To provide readily accessible supportive and therapeutic services for older citizens in the community.

(2) To maintain ongoing liaison and cooperation with other community services.

(3) To provide functional evaluation by means of which an appropriate supportive plan can be developed for each client.

(4) To provide supportive programmes and therapeutic services and to evaluate their effectiveness on an ongoing basis.

(5) To facilitate client involvement with other appropriate community services.

(6) To provide information for further identification and development of community services.

(7) To review the ongoing functioning of clients following discharge.

The attendance of the programme is 30-35 people per day, with some attending two days per week and some three days per week. In 1980, 89 people were admitted to the programme and in the first six months of 1981, 50 were admitted. As of August, 1981, the caseload was 76, of which the average age was 69, 67.5% were male, and 85.5% lived in the City of Hamilton. The average length of stay in the programme is between 6 and 12 months, but is very flexible based on the needs of the individual client. There were 20 people on the waiting list in August, 1981. These people were accepted into the programme but could not be admitted due to staffing and transportation difficulties. There are, on average, approximately 10 people on the waiting list. Most of the programme's clients come from the City of Hamilton, with a major cluster originating in the East End. In August, 1981 for example, 16 (21.1%) of the caseload lived in the East End of Hamilton or Stoney Creek.

Transportation arrangements are left to the individual, and most use the Disabled and Aged Regional Transit System (D.A.R.T.S.). D.A.R.T.S. buses in the early morning and late afternoon are all committed in the transportation of clients for work or education (see Transportation section). This creates problems for the staff of the day programme, in that they are never sure when the programme's clients will arrive in the morning or be picked up in the afternoon. In addition, client and family frustration at having to wait for transportation is evident, and potentially counteractive to the therapeutic goals of the programme.

St. Peter's Day Therapy Centre has operated since 1972 as an experiment in geriatric community support care. Initial funding was on a 50% basis from the Ministry of Community and Social Services under the Elderly Persons Centre Act with a maximum of $15,000.00. Currently, partial funding is provided through the Home Support Programme of the Ministry of Community and Social Services and the remainder is provided from the institution's internal global budget. The Victorian Order of Nurses (V.O.N.) originally provided a primary care nurse for two years, from their programme development fund, and a foundation provided block funding for a three-year start-up period. St. Peter's Hospital has considered their community role as well as their inpatient role by providing resources to the Day Therapy Centre where available, through adjustments in staffing, for example. The identification of the needs of the community has gone through many phases with emphasis from almost a strictly social-recreational service to care for the frail and sick elderly with a similar profile to the chronic hospital patients. This determination of potential need has been possible through the assistance of the chronic home care programme which, while keeping people in their homes, has also identified those who are vulnerable and in need of such support.

This assessment of need was responsible for an increase in the number of users from approximately 15 to 20 per day to 30 to 35 per day, and the Home Care Programme has noted a further need in the community sufficient to reach 50 per day. In addition, many people are deteriorating after discharge and repeating, suggesting the need for an expansion of service to include a maintenance programme.

Also, as of August, 1981, there were 12 people whose applications were on hold because, after referral to the programme, they were categorized by St. Peter's as confused ambulant and unable to participate in the existing day programme. Recognizing the need for separate day programming not only for these 12, but also for the confused ambulant group in the Region (see Confused Ambulant section), St. Peter's would like to expand the services

of the existing day programme and add some specific services for this group, including extra staff with special training in this area to provide personal care and supervision to assist the persons to participate in programmes, and additional space to promote safety, cleanliness and protection from wandering.

The administration of St. Peter's Centre feels that demands are increasing to the point where they can no longer be met under the current funding arrangement. Without additional funding, St. Peter's Centre may cut the programme back to former levels of 15 to 20 per day, rather than expanding to meet identified needs.

(b) Chedoke Continuing Care Centre Day Hospital Programme:

The Chedoke Division of the Chedoke-McMaster Hospital operates the Chedoke Continuing Care Centre Day Hospital Programme. The programme offers occupational therapy, physiotherapy, social work counselling, speech therapy and other hospital services needed by chronically disabled individuals in the Hamilton-Wentworth Region under age 65. The programme is not set-up to accept individuals with bladder incontinence or psychiatric disorders. All cases are referred through the Assessment and Placement Service by the family physician, regardless of where the case was originally identified. Most individuals who attend the programme live at home or in lodging homes, and many have recently had general or special rehabilitation.

Goals are set for each individual in the areas of physical functioning, social/interpersonal functioning, and emotional/psychological functioning. Improvement in all three of these areas was the goal for 29% of the 83 individuals involved in the programme at some time during 1980-81. For a further 22% the goal was maintenance or arrested decline of physical functioning and social/interpersonal and emotional/psychological functioning. Maintenance or arrested decline in all three areas was the goal for 49% of these people. Of the 27 people discharged from the programme in 1980-81, 18 (66.6%) had achieved the goals set for them. Of the remaining 9, 5 voluntarily left the programme or moved away and 3 did not achieve the goals set for them due to physical deterioration.

The programme's capacity is 30 people on any one day, with 50 registered at any one time, and a total of 83 people were involved in the programme in 1980-81. The median age of these 83 people was 50-59 and 59% were male.

For many individuals institutionalization is delayed through involvement in the programme, hence, the length of stay is flexible according to the individual's needs. While some individuals attend for short periods of time as family relief, the average length of stay is one year for 46% of the patient population and three months to one year for the balance. Currently there are, on average, 10 people waiting for two to three months to enter the programme.

As the majority of the programme's clients are not ambulant and require assistance travelling, the programme relies on D.A.R.T.S. for transportation. The system's buses, however, are all committed to the transportation of clients for work or education in the early morning and late afternoon (see Transportation). This creates problems for the staff of the day programme, in that they are never sure when the programme's clients will arrive in the morning or be picked up in the afternoon.

This service was initially funded under a federal government local initiatives programme, which lasted for three years. During that time its integral value to the chronic care system was demonstrated. Following the discontinuance of that source of funding the programme was submitted to, and approved in principle by the Ministry of Health. The Ministry recognized it as a very promising prospect for closing a well-known gap in maintenance health care services but, because of the fiscal constraints then in force, could not provide funds. The hospital then made a decision to maintain the programme on a "shoe-string budget" by utilizing resources out of its own global budget. Demands have increased to the point where they can no longer be met with the resources of the hospital. Hence, the overall viability of this programme is in jeopardy and, as with St. Peter's Day Programme, the hospital may have to cut back the programme rather than expanding to meet the demand.

(c) Seniors Activation Maintenance Programme:

This programme is currently being established at the Main and Hess Senior Citizen Centre in Hamilton. Under temporary funding through a Federal New Horizon's grant, it is hoped that the Ministry of Community and Social Services will provide permanent funding. It is intended that this programme will provide maintenance, accepting referrals from other day programmes such as St. Peter's Day Therapy, as well as from physicians and allied health personnel in the community. The programme will operate five days per week, and it is intended that individuals will arrange their own transportation through D.A.R.T.S.

(d) Macassa Lodge Outreach Programme:

Macassa Lodge, a 366-bed home for the aged, operates a day centre which is called the Outreach Programme, funded in part by the Ministry of Community and Social Services and in part by the Regional Social Services Department, for the frail and elderly living south of the escarpment. The primary purpose of the programme is socialization, and it hopes to provide an alternative to institutionalization for some clients. The programme runs five days a week and new clients start one day a week, coming more often as needed. Most clients are transported by Macassa's private van, although some clients in wheelchairs use D.A.R.T.S. A podiatrist is available through the Lodge one day a week.

The programme's capacity, dictated by the size of the dining room, is 24 per day. During 1980-81, 67 people entered the programme, most ranging in age from 60 to 90. The majority of referrals come from allied health personnel working in the community and currently there is no waiting list as the number of referrals is balanced by the number who can no

longer attend due to deteriorating health.

(e) St. Joseph's Villa Day Care:

St. Joseph's Villa, a 370 bed Home for the Aged, has recently established a day centre programme for the frail elderly one day per week. This is funded under the Home Support Programme of the Ministry of Community and Social Services and is in addition to the social/recreational Senior Citizen Centre operated 3 days/week by the Villa. Currently there are 12 clients and this number can be increased by 5 or 6 as the demand grows. While clients living anywhere in the Region may attend, the majority are from the Dundas area, accepting transportation by vans operated by the Dundas Recreational Centre.

Summation - Day Programmes:

As the number of day programmes in long term care grow in Ontario, so does the confusion over the distinctions between them. The Ministry of Health has suggested a basic split in the provison of day programmes to the frail or handicapped and are currently looking at establishing guidelines, particularly for funding and evaluation criteria. The current interest in day programmes reflects a general view that they are an important part of the continuum of long term care services, assisting in the efficient use of long term care beds.

Three of the five day programmes receive partial funding from the Ministry of Community and Social Services and the budgets of the two largest programmes - Chedoke Continuing Care Day Hospital and St. Peter's Centre Day Therapy - are heavily subsidized with funds taken from their respective global budgets. None of the programmes currently receives separate funding from the Ministry of Health. The Task Force notes that the District Health Council supported requests from the two largest

programmes for Ministry of Health funding in 1979 and that response to these requests was deferred by the Minister, pending the Task Force's final report. As this report documents, without this funding both programmes may be cut back by the administering institutions when they should be expanding to meet identified needs in the community.

Recommendation 1:

> The Task Force recommends that the Ministry of Health provide additional funding to the St. Peter's Centre Day Therapy programme and to the Chedoke Continuing Care Centre Day Hospital programme in order to allow for a sound base for current operations and the provision for needed future expansion.

In addition, the Task Force is concerned about the accessibility of the five day programmes to all parts of the Region. The programme at Chedoke is for the non-elderly and the Seniors Activation Maintenance programme accepts referrals from the other programmes for the elderly. Of the remaining three long term care day programmes, the programme at Macassa Lodge serves only those residents living south of the escarpment in Hamilton and has little potential to expand without first expanding physically. The day centre programme at St. Joseph's Villa, while initially small, has the potential to expand as it attempts to meet the need in the western part of the Region. St. Peter's Day Therapy programme, located near the centre of Hamilton, accepts clients from across the Region.

Residents of the east end of Hamilton-Wentworth who would benefit from long term care day programming, are limited to the availability of St. Peter's. The accessibility of this programme to residents of the East End, however, is hampered by distance and transportation problems. The Task Force feels that a separate day programme is necessary to serve the over 6,000 elderly who live in the East End, and is supported by a recommendation

of the East End Community Health Services Facility Task Force to establish a geriatric day therapy centre in the proposed East End Facility.

Recommendation 2:

> The Task Force recommends the establishment of a day therapy programme for the frail and handicapped elderly in the East End of Hamilton-Wentworth in conjunction with the development of the East End Community Health Services Facility.

2. Transportation

Definition:

Transportation refers to transportation for clients unable to use the regular transit system (Ontario Ministry of Health, 1980).

Background:

Many long term care patients are unable, due to physical disability, either to drive their own vehicle or use the public transit system. While family may provide transportation for some, this is not practical with most patients confined to a wheelchair. The availability of alternative transportation, then, is essential for many long term care patients to allow them to attend medical appointments and other health related services or continue functioning in the community through work, education and recreation.

Of particular concern to the Long Term Care Task Force is the unavailability of alternative transportation for health purposes. The success or failure, for example, of long term care day programming can be greatly influenced by the availability of transportation.

Inventory - Transportation:

The major provider for such transportation in the Region is the Disabled and Aged Regional Transit System (D.A.R.T.S.). D.A.R.T.S. began service in 1976 with the consolidation of several smaller transportation services under a central radio dispatched authority. Determining the need for this service prior to its establishment was very difficult - a pre-inauguration survey indicated that approximately 10 people would use the service. Since its establishment, the demand for the service has grown steadily. Currently, D.A.R.T.S. operates 18 buses (2 are spares) Monday to Friday from 7:00 a.m. to 7:00 p.m. and operates 2 buses during weekday evenings until 11:00 p.m. The service receives 50% of its funding from the Ministry of Transportation and Communications and charges a fare comparable to that of using the public transit system.

Statistics on the number of trips made for the 1980 calendar year are summarized in Table 12. The total of 90,053 represents an increase of 37.4% over 1979. The priorities for the service are established by the Ministry of Transportation and Communications as follows:

1. work
2. education
3. medical
4. recreation

New applications to D.A.R.T.S. for service have increased considerably over the past year, to the point where all of the D.A.R.T.S. buses are committed to transporting clients to and from work and education in the early morning (approximately 7:00 a.m. to 9:30 a.m.) and late afternoon (approximately 2:30 p.m. to 5:00 p.m.). This means that transportation for medical purposes, including medical appointments, therapy, and day programming, and for recreational purposes can only be provided from late morning until early afternoon and, to a limited extent, in the evening.

A recent announcement by D.A.R.T.S. indicated that, effective November, 1981, D.A.R.T.S. drivers are allowed only a three minute loading period and are not permitted to leave their vehicles unattended to enter user or institutional premises. In addition, medical appointments must be arranged 48 hours in advance and pick-ups and returns must occur between 10:00 a.m. and 1:30 p.m. An expansion of this service has been suggested in order to meet the increasing demand, which is one of the goals of the service (D.A.R.T.S., 1980).

While D.A.R.T.S. is the major provider of transportation to long term care clients in the Region, other agencies assist in meeting the demand. The Home Care Programme, sponsored by the Victorian Order of Nurses (V.O.N.), made use of the Regional Ambulance Service for 434 trips during the fiscal year 1980-81. These trips were made to transport Home Care clients between home and hospital or doctor. The actual breakdown of emergency vs. scheduled trips is not available, however, the Administrator of the Home Care Programme indicated that the majority of these were

Table 12

D.A.R.T.S.

Usage Summary Report
for the Year Ending December 31, 1980

Vehicles used in 1980	16
Passengers Carried	90,053
Miles Travelled	381,748
Charters	199
Passengers on Charters	2,340
Number of Passengers Using Service for:	
Work	28,025
Medical Purpose	12,651
Day Care	32,321
Shopping	761
Education	8,168
Social & Recreation	4,036
Therapy	4,071
Other (meetings, etc.)	20
Total	90,053

Increase over 1979, 37.4%

Source: Disabled and Aged Regional Transit System of Hamilton-Wentworth Annual Report, 1980.

emergency related. In addition, the Friendly Visitor and Family Support Programme provided 284 trips for Home Care clients in 1980, through five volunteer drivers. These trips were made for social or medical reasons and were assessed by the Victorian Order of Nurses as unable to be met by other means (e.g. D.A.R.T.S., ambulance, public transit), as these clients required assistance in dressing or walking, etc.

The Canadian Red Cross Corps Service began a transportation service in January, 1981 and in the first six months have provided transportation for 20 people, free of charge. It is a limited service, with one vehicle available weekday mornings, and the majority of visits are for short-term out-patient therapy at the Henderson or Chedoke Hospitals. The demand for these trips in the morning is related to the unavailability of D.A.R.T.S. as mentioned above. In addition, as volunteers with other transportation services go on holiday, the Red Cross service has been providing transportation to some of their clients. In July, for example, 19 persons were transported.

The Canadian Cancer Society provides transportation to and from the Cancer Clinic or area hospitals for patients of the Clinic. There are four branches of the Cancer Society in the Region - Hamilton, Hamilton Mountain, Stoney Creek and Dundas - each providing transportation for patients of the clinic in their area. Combined, they provided transportation for approximately 100 persons per week in 1980-81.

As part of its programme of Home Support Services to Seniors, Family Services of Hamilton-Wentworth has started an Escort Service to complement the social visiting component of the programme. As such, it is intended that the number of trips made will be few, and there are no statistics yet available.

Summation - Transportation:

The Disabled and Aged Regional Transit System provided approximately 98% of all transportation for long term care clients unable to use the regular transit system in 1980-81. The priorities set by the Ministry of Transportation and Communications for the service are work, education,

medical and recreation, in that order. Within these priorities, trips for medical and other health related purposes cannot currently be made in the early morning or late afternoon. This has implications for all long term health services, but particularly for day programmes that are dependent on D.A.R.T.S. to transport their clients daily. The Task Force notes that unless D.A.R.T.S. is adequately subsidized, it will not be able to expand to meet all of the long term care transportation needs in the Region.

Recommendation 3:

> The Task Force recommends that the Ministry of Health, through discussions with the Ministry of Transportation and Communications, examine the issue of low priority and resulting restricted availability of D.A.R.T.S. transportation for health purposes, and the issue of adequate subsidization of D.A.R.T.S. to enable it to expand to meet all of the long term care transportation needs in the Region.

Other services are attempting to meet some of the demand for transportation in the medical and social/recreational areas. Transportation is available to Home Care clients and patients of the Cancer Clinic. The Red Cross Corps Service and the Family Services Escort Service are two small transportation programmes recently established to provide service to people not on Home Care, and their impact on the availability of transportation should be monitored.

With the establishment of new, smaller transportation services, the potential for problems relating to a lack of communication and coordination increases. Coordination of these services would allow an increased awareness of their existence on the part of agencies and potential clients in the community, and would reduce unnecessary mileage in their transportation.

Recommendation 4:

The Task Force recommends that the Health Council, in cooperation with those involved in long term care transportation, work towards the Region-wide coordination of this service.

3. Senior Citizen Housing

Definition:

Senior Citizen housing refers to accommodation provided specifically for the elderly. Rents may be geared to income (Long Term Care Task Force).

Background:

Many older people in Ontario own and live in their own homes and, as suggested by the Twelve Gerontological Principles presented in the introduction to this report, most would prefer to live in their own homes as long as possible. Maintenance and the cost of upkeep, however, force many to look for alternatives, regardless of their personal health.

A major alternative for those who are ambulant and well is socially assisted housing, funded jointly by the Federal and Provincial governments and operated under the Ontario Housing Corporation (O.H.C.).

As senior citizen housing complexes built in the 1950's and 1960's age, however, so do their tenants, often resulting in an increasing need for health and community support services to the residents. A study of the health needs of senior citizens in such housing in York Region has shown that this is often the cause of anxiety on the part of the residents which can be lessened by the inclusion of meal services, a convenience food store nearby, the addition of warden systems and by an increase in the availability of nursing services (Kirstine, 1976).

With any senior citizen housing arrangements, the problem of the transition from self-care to assisted care, which often involves a shift in Ministerial responsibility from Housing to Health, exists to varying degrees. Without adequate health and social support, senior citizens may be forced to give-up their housing arrangements, even though their health needs may be temporary. Alternatively, when residents become confused or debilitated physically or mentally, the question of who is responsible for their care is raised. Often they do not wish to leave their accommodation, yet cannot adequately look after themselves with the community support

services available. This creates problems where a need has been identified to transfer an individual to an alternative type of care, which quite often requires the enforcement of the transfer under the Mental Health Act.

Another problem exists when spouses are separated, and one spouse is institutionalized leaving the other alone. Often the one left cannot continue to cope within the same housing arrangements, particularly when the institutionalized spouse's pension goes to the institution. The problem of separation of spouses becomes most extreme when both are institutionalized, but in different facilities; one in a nursing home and one in a chronic hospital, for example. One alternative may be the establishment of multi-level care facilities, allowing individuals to progress through levels of care, in one location.

The Oakville Senior Citizen's Residence represents one such public alternative. This complex comprises a home for the aged under the Ministry of Community and Social Services and subsidized apartments under the Ministry of Housing. The two are joined by a large dining hall which is utilized by both.

Other similar projects have been undertaken by voluntary organizations, often under church sponsorship. One such example is the St. Joseph's Heritage in Thunder Bay, which combines a nursing home, senior citizen's apartments, a community centre for all age groups, a restaurant and service facilities (Short, 1980).

As the Ontario Council of Health has suggested, there are insufficient housing alternatives as aging proceeds and health problems become more frequent, when the provision of these alternatives may help to alleviate the pressure on health care services (Ontario Council of Health, 1978). The Task Force agrees with the Council of Health that more coordination between Ministries is necessary to ease the transition from self-care to assisted care, and to ensure the coordination of care when an individual crosses jurisdictional boundaries between various Ministries.

Inventory - Senior Citizen Housing:

Tables 13 to 15 summarize the inventory of assisted housing for senior citizens in Hamilton-Wentworth. Table 13 shows that the number of units available in the Region increased gradually from year end 1975 to year end 1978, and with the introduction of several privately sponsored complexes, increased by year end 1980 to 4,450 units. Table 14 further breaks down the type and location of these 4,450 units, 97% of which are located in the City of Hamilton.

Table 15 lists the number on the waiting list for housing by area municipality for year end 1978, 1979 and 1980. While the number of applications waiting has varied over the last 3 years, the high rate of applicant rejection of available units normally experienced by the Ontario Housing Corporation means that the waiting list may not accurately represent the need for assisted housing. For example, over 900 of the Regional total of assisted housing units for senior citizens are bachelor units, built in the 1950's and 1960's, which are often rejected by seniors who would prefer to remain on the waiting list for a larger apartment. If an individual rejects two reasonable offers of bachelor apartments, however, he/she is removed from the waiting list and must re-apply if housing is still desired.[1]

The need for additional government assisted housing units for seniors is usually based on a municipal survey with an examination of the waiting list by the Ontario Housing Corporation. The last such needs assessment for the City of Hamilton was done in September 1978, and there are no immediate plans to increase the number of its units available, given that over 100 bachelor units are currently vacant. Such needs assessments have recently been completed in Stoney Creek and Dundas and discussions with the Ministry of Housing are being pursued by these municipalities.

Currently, there are no assisted housing buildings for seniors operated by the Hamilton-Wentworth Housing Authority in the Region with built-in

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[1]-Mr. Byron Hill, Hamilton Area Manager, Ontario Housing Corporation.

Table 13

Assisted Housing Units for Senior Citizens in Hamilton-Wentworth at Year End, 1975 to 1980

	1975	1976	1977	1978	1979	1980
Hamilton	2317	2667	2714	2872	4221	4314
Dundas	29	29	29	29	29	29
Stoney Creek	42	42	43	43	43	43
Flamborough	---	---	---	---	9	9
Ancaster	---	---	45	45	45	45
Glanbrook	---	---	---	---	---	---
Regional Total	2388	2738	2831	2989	4347	4450
Annual Change	---	350	93	158	1358	103
Percentage Change	---	14.66	3.40	5.58	45.43	2.37

Source: Planning and Development Department of Hamilton-Wentworth:

(1) Monitoring the Housing Market - City of Hamilton, 1977.

(2) Monitoring of Housing Development, 1978.

(3) Housing and Population Monitoring Report, 1979.

(4) Monitoring The Housing Market - City of Hamilton, 1979.

(5) Housing and Population Monitoring Report, 1980.

Table 14

Inventory of Senior Citizen
Assisted Housing Units in
Hamilton-Wentworth, December 31, 1980[1]

MUNICIPALITIES	PROGRAM	SENIOR CITIZEN UNITS
Hamilton	Public Housing OHC	3041
	Rent Supplement	402
	Private Non-Profit	871
	SUB TOTAL	4314
Stoney Creek	Public Housing OHC	43
Dundas	Public Housing OHC	29
Ancaster	Public Housing OHC	45
Flamborough	Rent Supplement	9
TOTAL REGION		4450

[1]-Inventory does not include units under the Limited Dividend Programme. (In 1976 approximately 1,400 Limited Dividend Units existed).

SOURCE: Planning and Development Department of Hamilton-Wentworth, "Housing and Population Monitoring Report", 1980.

Table 15

Number of Applicants on Waiting List
for Senior's Assisted
Rental Accommodations,
Year End, 1978, 1979, 1980

Municipality	Senior Citizens 1978	1979	1980
Hamilton	263	157	231
Stoney Creek	31	28	21
Dundas	17	18	16
Ancaster	9	7	10
Flamborough	--	--	--
Glanbrook	--	--	--
Regional	320	210	278

Source: 1978, 1979: Planning and Development Department of Hamilton-Wentworth, "Housing and Population Monitoring Report", 1979.

1980: Hamilton-Wentworth Housing Authority

cafeteria services or warden systems. In 1980, 193 residents of senior citizen's apartments in Hamilton-Wentworth received Meals-on-Wheels. Public Health nurses are assigned to each of the Ontario Housing units for seniors. In some instances, they have space where seniors may come for minimal foot care, monitoring of blood pressure, medications, nutrition counselling, etc. Nurses also visit seniors in their apartments and in homes in the community. Home Care is also available to those residents of senior citizen housing who meet the eligibility criteria.

Apart from the government subsidized housing for seniors, there are several housing projects in the Region sponsored by private interests (see Inventory). Some of these combine housing with social support and health services, for example, cafeterias, recreational facilities, shopping facilities, space for a physician to set up practice, charitable home for the aged beds or rest home beds.

Summation - Senior Citizen Housing:

Senior citizen housing in the Hamilton-Wentworth Region is provided by the Ontario Housing Corporation through the Hamilton-Wentworth Housing Authority; by private enterprise into which the Housing Authority coordinates placement; and by private enterprise with private placements.

The identification of the need for senior citizen housing generally rests with the municipality and, while the Hamilton-Wentworth Housing Authority does not currently plan to add any additional units to its inventory, several projects are planned by private interests. Some of these will provide multi-level health care and social support services to prevent or delay institutionalization and smooth the eventual transition from self-care to assisted care.

As aging proceeds and health problems become more frequent, however, other health and social support services provided in conjunction with senior citizen housing and available community support are required, as are improved mechanisms for transfer to alternative care.

Recommendation 5:

The Task Force recommends that the Health Council, in conjunction with the Public Health Unit, initiate discussion with the Hamilton-Wentworth Housing Authority to facilitate the establishment of warden systems, meals services and space for public health services in senior citizen residences; and to plan adequate mechanisms for transfer to alternative types of care when a resident is no longer able to manage the activities of daily living with available home support services.

4. Care in the Home

4.1 Home Care Programme:

Definition:

Home Care Programme refers to the Province's O.H.I.P. insured visiting treatment service with some homemaking if required, for clients meeting the entry criteria (Ontario Ministry of Health, 1980).

Background:

The Hamilton-Wentworth Home Care Programme, established in 1966, was the third such programme to operate in the Province. Currently, there are 38 Home Care Programmes in the Province. The Hamilton-Wentworth Programme includes both an acute and a chronic component, and is administered by the Victorian Order of Nurses (V.O.N.).

The two major objectives of the programme, as stated by the Ministry of Health, are the provision of care for the patient in the home where this location is appropriate and is in the best interest of the patient's well-being; and, the avoidance or reduction of costs of patient care by avoiding the need for admission to hospital or other institution or by reducing this length of hospital stay through earlier discharge to home care (Short, 1981). The literature suggests that, while more extensive evaluation is necessary, home care is a better alternative than institutionalization under certain conditions (Nestman and Bay, 1981).

Under the acute programme, drugs, dressings and medical supplies are paid for, along with diagnostic and laboratory services, hospital and sickroom equipment, and some transportation. In addition, nursing, physiotherapy, occupational and speech therapy, social work services, nutrition counselling and homemaker services are provided under the programme. A maximum of 80 hours of homemaking per client is available.

Clients are referred by a physician and assessed according to nine

currently established criteria.[1] Treatment is based on goals established on acceptance in the programme, and clients are reassessed regularly while on the programme.

Hamilton-Wentworth was selected as one of three areas in Ontario to undertake a pilot Chronic Home Care Programme. An added goal for this programme is to prevent or delay deterioration in the client's condition and/or to prevent or delay admission to a nursing home or other institution. A minimum of three nursing or therapy visits per month are required and a maximum of 80 hours of homemaking per client in the first month and 40 hours per month thereafter are available (McNairn, 1979). An evaluative study of the chronic home care programme is underway, with projected completion date in 1983.

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[1] (1) The patient is insured under O.H.I.P.
(2) The patient is under the medical supervision of an attending physician.
(3) The patient's medical condition is such that he can be treated adequately at home with the services available through the home-care programme.
(4) The patient's needs cannot be met on an outpatient basis.
(5) The patient is in need of at least one of the professional services such as nursing, physiotherapy, occupational therapy, and speech therapy. (Homemaking does not qualify in the category of professional service).
(6) The home is suitable to enable the required care to be given.
(7) The patient's family is willing and able to participate in the programme where and when required.
(8) The patient resides in the area designated as being covered by the home-care programme.
(9) The patient's professional treatment is reasonably expected to result in patient progress toward established goals for rehabilitation. When progress is no longer apparent, the patient is transferred to an alternative and appropriate mode of care.

Inventory - Home Care Programme:

Table 16 shows that the total caseloads of both the acute and chronic Home Care Programmes in Hamilton-Wentworth have increased steadily from 1977-78 to 1980-81. In 1980-81, 55.2% of the acute caseload and 80.6% of the chronic caseload were age 65 or over.

The average length of stay for the acute programme was 27 days in 1978-79 and 1979-80, and 26 days in 1980-81 (Table 17). For the chronic programme, the average length of stay was 133 days in 1978-79 and 1979-80, and 196 days in 1980-81. This compares with an average of 32 days for the rest of the acute Home Care Programmes in the Province in 1979-80, and 126 days for the rest of the chronic Home Care Programmes in the Province in 1979-80.

Table 18 shows that the majority of acute programme clients come from active treatment hospitals, and are discharged to their own home. Table 19 indicates that the opposite is true for clients of the chronic programme.

Current eligibility criteria do not allow those who require only homemaker services to receive them under the Home Care Programme. In 1980-81, approximately 790 referrals to the Home Care Programme were refused because they were assessed as not requiring one of the professional services. Many of these required only homemaker services and were referred to other homemaker services available in the community on a fee for service basis.

Summation - Home Care Programme:

The Chronic Home Care Programme has been operating in Hamilton-Wentworth since 1975 and has quickly built a large caseload. While it is generally accepted that the programme is meeting its goal of preventing or delaying institutionalization, an evaluation is underway and the results will not be available until 1983. The Ministry of Health is committed to the provision of chronic home care in all areas of the Province.

Recognizing the importance of homemaker services in assisting those who need help to stay in their homes as long as possible, the Task Force

Table 16

Hamilton-Wentworth Home Care Programme:
Age of Total Caseload

	Acute			Chronic		
	Total Caseload	% < Age 65	% ≥ Age 65	Total Caseload	% < Age 65	% ≥ Age 65
1977-78	3867	----	----	1885	----	----
1978-79	3981	47.8	52.2	2191	21.0	79.0
1979-80	4723	47.6	52.4	2781	16.3	83.7
1980-81	5059	44.8	55.2	2990	19.4	80.6

Source: Hamilton-Wentworth Home Care Programme Annual Reports, 1978-79, 1979-80, 1980-81

Table 17

Hamilton-Wentworth Home Care Programme:
Average Length of Stay Compared with Province[1]

	Acute		Chronic	
	Province	Hamilton-Wentworth	Province	Hamilton-Wentworth
1978-79	----	27 (days)	----	133 (days)
1979-80	32 (days)	27 (days)	126 (days)	133 (days)
1980-81	----	26 (days)	----	196 (days)

Source: Hamilton-Wentworth Home Care Programme Annual Reports, 1978-79, 1979-80, 1980-81

[1]-Average length of stay for all Home Care Programmes in the Province

Table 18

Hamilton-Wentworth Home Care Programme:
Location at Time of Referral of Admissions and Discharge Disposition, Acute Programme

	Location at Time of Referral				Discharge Disposition			
	Hospital		Other		Other		Home	
	Number	%	Number	%	Number	%	Number	%
1977-78	2121	73	780	27	----	--	----	--
1978-79	2564	68	1186	32	1371	38	2237	62
1979-80	3050	70	1303	30	1920	44	2444	56
1980-81	3043	65	1660	35	2028	43	2689	57

Source: Hamilton-Wentworth Home Care Programme Annual Reports, 1978-79, 1979-80, 1980-81

Table 19

Hamilton-Wentworth Home Care Programme:
Location at Time of Referral of Admissions and Discharge Disposition, Chronic Programme

	Location at Time of Referral				Discharge Disposition			
	Other		Home		Hospital		Other	
	Number	%	Number	%	Number	%	Number	%
1977-78	456	33	938	67	----	--	----	--
1978-79	469	33	956	67	705	53	625	47
1979-80	505	47	1416	53	896	53	795	47
1980-81	546	29	1352	71	955	52	882	48

Source: Hamilton-Wentworth Home Care Programme Annual Reports, 1978-79, 1979-80, 1980-81

feels that access to homemaker services would be greatly improved if they were available under the Home Care Programme to all who need them. Currently this is not the case and statistics from 1980-81 show that almost 800 referrals to the Home Care Programme were refused because they did not require professional services, regardless of whether homemaker services were needed or not. At the same time, the Task Force notes the proposed expansion of homemaker services announced jointly by Dennis Timbrell, Minister of Health and Frank Drea, Minister of Community and Social Services in October 1981, and anticipates further announcements which will specify the exact nature of the proposed expansion. In the meantime, the Task Force makes the following recommendation.

Recommendation 6:

> The Task Force recommends that the Ministry of Health expand the eligibility criteria for the Home Care Programme to allow access for those who require only homemaker services.

4.2 Respite Care in the Home:

Definition:

Respite Care in the home refers to temporary alternative arrangements for a client to allow the usual supervising and/or assisting persons relief from care of the client. This may be provided by other than health personnel, in the client's home setting (Long Term Care Task Force).

Background:

The availability of this type of care, allowing the family or usual care giver the opportunity of short term relief from caregiving, can make the difference between keeping a patient at home or not. Without this opportunity, the family may not be able to cope with the provision of continuous care, resulting in an institutionalization that is inappropriate. Respite care in the home is usually provided for a period of a

few hours, to allow the usual caregiver temporary relief from the responsibility of giving care.

Inventory - Respite Care in the Home:

Several groups are identified as providing such relief from care in the Hamilton-Wentworth Region. The Victorian Order of Nurses sponsors a Family Support programme in conjunction with the Home Care Programme. In the 1980 calendar year, 200 Family Support volunteers spent approximately 10,500 hours providing short term relief to 222 caregivers. This service is available during office hours on weekdays to clients of the Home Care Programme at no cost to the client.

The Regional Social Services instituted an Attendant Companion Programme which has, since February, 1981, been offering short term relief from care Monday to Thursday, 4:00 p.m. to 12:00 p.m. and Friday 4:00 p.m. to Saturday 12:00 p.m. The need for this programme was identified through the number of emergency requests for short term relief from care made on the Helping Hands Programme (see Other Care in the Home). Awareness of the programme on the part of the community and professionals has increased over the first six months of operation to the point where 90 clients are registered, with 40 active at any one time. The Regional Social Services Department is monitoring the demand on the programme, as it is expected that the number of clients will increase as awareness of the programme increases.

The Canadian Cancer Society offers an Adult Sitting Programme through which 37 volunteer visitors spent approximately 4,000 hours providing short-term relief to the normal caregivers of cancer patients in their own homes in the 1980 calendar year. It was noted by the programme coordinator that during the year, the programme was unable to respond to the request of at least 10 patients, who were referred to other programmes.

Other organizations in the Region provide limited respite care in the home. For example, the Red Cross Homemakers service provides some short-term relief from care, but generally as an adjunct to their homemaking

service. Similarly, the Visiting Homemakers Association of Hamilton-Wentworth Inc. provides some relief from care in conjunction with its homemaker service. In both cases, however, the primary service provided is a homemaker service and the actual number of respite care cases is not available. Most commercial agencies which provide private homemaking and home nursing also provide "companion aid", or respite care in the home, to paying clients.

Summation - Respite Care in the Home:

Respite care in the home is usually available to clients of the Home Care Programme and to cancer patients. Its availability to the remainder of the long term care population, however, appears limited to that provided by the Regional Social Services Department's Attendant Companion Programme and services offered in conjunction with visiting homemaking. Of these services, the Attendant Companion Programme has only recently begun to provide this type of care, and should be monitored for its effect on the overall availability of this type of care.

As in any case where several agencies are involved in the provision of a particular type of care, the potential exists for problems relating to a lack of communication and coordination. A centralized coordination of this service would both enhance its provision and allow a more accurate monitoring of unmet need.

Recommendation 7:

> The Task Force recommends that the Services to Seniors Division of the Regional Social Services Department, in conjunction with the Assessment and Placement Service, monitor the provision of respite care in the home with a view to identifying unmet need.

4.3 Other Care in the Home

Apart from the Home Care Programme and respite care in the home, there are many other community support services which form a very important part of the continuum of long term care services. While no recommendations are made, the Task Force wishes to acknowledge their importance by their inclusion here.

(a) Homemaker Services:

Homemaking refers to a service usually provided by non-health personnel which may include light housekeeping, meal preparation, and some personal care. While homemaker services are available to clients of the Home Care Programme, and are thus paid for through O.H.I.P., homemaker services are also available in the community on a fee for service basis. In Hamilton-Wentworth there are five agencies providing homemaking to clients not eligible for the Home Care Programme.

In 1980, the Visiting Homemakers Association provided homemaking to 441 clients not on the Home Care Programme and in some cases clients are subsidized by the Regional Department of Social Services or through funds received by the Association from the United Way. In the first six months of 1981, the Association has provided homemaking to 286 clients not on the Home Care Programme. The Red Cross Homemakers made 2,866 homemaking visits to 46 clients not on Home Care in 1980, and in the first six months of 1981 have made 1,139 homemaking visits to 27 clients. This service is limited to the Dundas area, and some clients are subsidized by the Regional Department of Social Services.

Para-Med Health Services is a private firm providing both a homemaker service and home nursing. In 1980 they provided 21,797 hours of homemaking and to October 1981, they have provided 25,272 hours of homemaker service. Comcare and Upjohn Health Care Services are also private firms providing a homemaker service in the community.

(b) Home Nursing:

Apart from the Home Care Programme, home nursing visits are provided by public health nurses, by the Victorian Order of Nurses, the St. Elizabeth's Visiting Nurses and by private nursing firms.

In 1980, public health nurses made 14,855 visits to people over the age of 65 not on the Home Care Programme. These visits to seniors not on the Home Care Programme comprised 95% of public health nursing visits to seniors in that year and were funded 75% by the Ministry of Health and 25% by the local municipality. The Victorian Order of Nurses (V.O.N.) made 2,614 home nursing visits apart from the Home Care Programme in 1980 and, in the first six months of 1981, have made 1,407 visits. In contrast to the home nursing provided by the public health, these visits represent less than 3% of the total made by the Victorian Order of Nurses. While some patients pay the full cost of this service, the majority are subsidized by the Regional Department of Social Services. Almost all of the home nursing visits provided by the St. Elizabeth Visiting Nurses Associaton are provided in conjunction with the Home Care Programme.

The Community Nursing Registry, owned and operated by Nurses, is a non-profit registry of self-employed R.N.'s and R.N.A.'s and Health Care Aids. In 1980 approximately 1,300 home nursing visits were made by these nurses to private clients. As of September 1981, approximately 1,000 visits had been made.

Medical Personnel Pool, a private nursing firm, supplied 15,170 hours of private home nursing in 1980 and, in the first six months of 1981, have supplied 10,574 hours of home nursing. Para-Med Health Services provided 4,802 hours of private home nursing in 1980 and, to October 1981, they have provided 6,097 hours. Comcare provided 65,631 combined hours of private homemaking and home nursing to 1,410 clients in 1980. In the first six months of 1981 they provided 41,499 combined hours of private homemaking and home nursing to 764 clients. Other private home nursing is provided by Upjohn Health Care Services.

(c) Meals-on-Wheels/Wheels-to-Meals:

Meals-on-Wheels is a service which delivers a meal to a client's residence on pre-arranged days. Wheels-to-Meals is a service which provides transportation between a client's residence and a central location where meals are served. Meals-on-Wheels fulfills a practical need by providing a hot, nutritious meal to those who cannot prepare meals themselves, while Wheels-to-Meals has the added goal of socialization.

Five programmes were identified in a report by the Social Planning and Research Council (Orr, 1981). The Victorian Order of Nurses runs the Meals-on-Wheels programme below the escarpment in Hamilton and Stoney Creek, which had 666 clients in 1979. Macassa Lodge runs a Meals-on-Wheels programme and a Wheels-to-Meals programme for residents living on the mountain in Hamilton. Their Meals-on-Wheels programme had 159 clients in 1979, and their Wheels-to-Meals programme had 78 clients in that year. An association of local churches runs the Meals-on-Wheels programme in Dundas, with 53 clients in 1979, and 16 clients received Meals-on-Wheels from the programme in Waterdown, run by the local branch of the Canadian Red Cross. Together, these programmes provided some 85,000 meals to 972 clients in 1979. In each of these programmes, the majority of clients were over age 80; the majority were women; and the majority lived alone.

A new Meals-on-Wheels service has recently been started in the Town of Ancaster, but does not extend into the rural parts of the municipality. Thus, while the areas of major population concentration in the Region have some service available, there is no service in the rural areas of Glanbrook, Ancaster or Flamborough. In addition, none of the current programmes provide service on weekends.

(d) Home Help:

The Helping Hands programme provides non-professional home maintenance services to the non-institutionalized elderly and physically handicapped (living in their own or rented accommodation). There are over 4,000 clients registered with the programme, approximately 2,500 of which are currently active, requesting home help on an occasional basis.

The Regional Social Services Department operates the programme, which is cost shared with the Ministry of Community and Social Services and, currently, 26 helpers provide this home maintenance help. One of the purposes of the programme is to enable people to remain in their own living environment for as long as possible, potentially preventing institutionalization. As the programme is still growing and developing, its full impact cannot be identified at this time.

(e) Daily Telephone Contact:

Teletouch (seniors) provides a daily telephone contact to ensure the health and well-being of senior citizens, the handicapped, or those who live alone and may or may not be able to venture out, in the Hamilton-Wentworth Region and surrounding areas. If the services of other agencies are required, steps are taken to assist the client and contact made to the proper source. Clients are referred by family members, friends, public health nurses, physicians, churches, or other social agencies in Hamilton and surrounding communities. Currently, there are over 650 clients in the area from Oakville to Grimsby, who are contacted by approximately 450 volunteers.

Chapter 5

INSTITUTIONAL-BASED LONG TERM CARE SERVICES

1. Residential Care

Definition:

Residential Care refers to the care required by a person who is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition (Ontario Ministry of Health, 1975).

Inventory - Residential Care:

This discussion will focus on long term residential care provided by homes for the aged and lodging homes.[1] In Hamilton-Wentworth, there are five homes for the aged providing 672 residential care beds. Two of these homes are municipal homes for the aged and three operate under the Charitable Institutions Act. On March 31, 1981, 632 of these beds (94.0%) were occupied. One home (59 beds) provides the residence for the Canadian National Institute for the Blind (C.N.I.B.) in Hamilton and, as such, approximately 50% of the residents are under age 65. Another of the five homes serves elderly women only and a third home has two satellite homes associated with it. These small satellite homes provide more freedom for their seven residents, yet allow them the benefit of using all of the services provided by the homes for the aged.

The Ministry of Community and Social Services and the local

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[1]-Residential long term care is also provided to specific target groups in Homes for Special Care, residences for the mentally retarded, alcoholic rehabilitation residences, and residential facilities for children and adolescents. See "Appendix A" for an inventory of these facilities.

municipality will subsidize, on a 70/30 split, the global deficit of the municipal homes caused by residents unable to pay the full cost of this care. In the homes for the aged which operate under the charitable Institutions Act, the unpaid balance is subsidized by the Ministry of Community and Social Services (see Appendix A Inventory). Each of the homes maintains its own waiting list, which are not mutually exclusive, as the same person could potentially be on several lists at the same time.

Of the 53 lodging homes in the Region there are 46 with a second level license and 27 of these, with a capacity for 426 residents, have entered into an agreement with the Regional Social Services Department as hostels under the General Welfare Act. Where a home has residents who require someone on duty 24 hours a day able to offer guidance in the activities of daily living, they must have a second level license.

A survey of these homes carried out in September and October, 1981 indicated that of the 27 contract homes, 9 have as their primary target group the elderly or infirm. The survey noted that 96 of the 383 current residents (25.1%) are over the age of 65, and 65.5% are male. The status of these current residents is as follows: 62.7% are post psychiatric patients; 29.0% are elderly and infirm; 3.9% are alcoholic; 2.9% are mentally retarded; and 1.6% are physically handicapped. The average occupancy rate of these homes in 1980 was 84.7%.

Seventy-six persons recommended by the Assessment and Placement Service were placed in residential care in homes for the aged in 1980-81, and 95 persons found accommodation in lodging homes. While the average length of wait for admission in that year was 105.0 days, the length of wait for homes for the aged was longer than that for lodging homes. Both homes for the aged and lodging homes accept residents without recommendation from Assessment and Placement Service.

Accessibility - Residential Care:

Of the 672 residential beds in homes for the aged in the Region, 334

are located in the City of Hamilton and the remaining 338 are in Dundas. The two small satellite homes are associated with one of the homes for the aged in Hamilton. There are no homes for the aged in Stoney Creek, Ancaster, Flamborough or Glanbrook. All of the 27 contract lodging homes, representing 426 residential care beds, are located in the City of Hamilton (see Table 6).

Summation - Residential Care:

It is difficult to assess the need for residential long term care in Hamilton-Wentworth, as there are no Provincial guidelines regarding minimum bed requirements, and not all placements are coordinated through the Assessment and Placement Service. Currently, there are 672 residential beds in homes for the aged in the Region, approximately half of which are located in Hamilton and half of which are in Dundas. Normally, an individual home will submit a proposal to the Ministry of Community and Social Services for expansion of these beds, based on their own waiting list. There is, however, a freeze on such expansion, both in the homes for the aged and in the satellite homes.

The Task Force notes that each home for the aged maintains its own list, and that these lists are neither mutually exclusive nor centrally coordinated. A central coordination of these lists, through the Assessment and Placement Service, would facilitate their use as a planning tool, similar to the way in which waiting lists for other institutions are used, and would further assist the coordination of placements to these beds.

Recommendation 8:

> The Task Force recommends that the Assessment and Placement Service, in cooperation with homes for the aged in the Region and the Ministry of Community and Social Services (COMSOC), work towards the centralization of waiting lists for residential care in homes for the aged, to allow their use for planning purposes, and to assist the further coordination

of placements to residential care beds in homes for the aged.

Currently there are 426 residential beds in 27 contract lodging homes in the Region, all of which are located in the City of Hamilton. A problem common to lodging homes in many jurisdictions relates to a lack of standards and recognition under legislation. The second level lodging house by-law, to which these 27 contract homes conform, however, goes a long way to alleviate this problem, by legislating certain standards to ensure a higher level of care than that provided in ordinary lodging homes.

A report prepared by the Social Planning and Research Council of Hamilton and District on contract lodging homes concluded that these homes occupy a key position along a continuum of care alternatives, and that shortage of beds is not currently a problem. The report did, however, note the lack of programmes in the community for residents of these homes which would improve existing custodial care and introduce rehabilitative care (Orr, 1981). The Task Force wishes to support the Social Planning and Research Council in its continued work in this area.

2. Extended Health Care

Definition:

Extended health care refers to the care required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24 hour basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years (Ontario Ministry of Health, 1975).

Inventory - Extended Care:

Currently in Hamilton-Wentworth, there are in operation 1,074 extended care beds in nursing homes (1,237 - 163 homes for special care beds[1]) and 441 extended care beds in homes for the aged, for a total of 1,515 extended care beds. In February, 1981, in response to the interim report of the East End Community Health Services Facility Task Force, 100 new extended care beds were approved by the Minister of Health. When the tenders were reviewed and the licences issued, a total of 83 new extended care beds were added to the existing number. Seventeen extended care beds of the 100 approved had been operating under a temporary licence for 2 years. Of the total new beds licenced, 61 will be new construction and will be available for use early in 1983. In addition, 33 beds were removed from the system in April, 1981, when a nursing home in Hamilton closed. The licence for these 33 beds has subsequently been purchased and will be re-opened in November, 1981.

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[1]-The actual number of homes for special care beds in nursing homes in Hamilton-Wentworth in 1980-81 fluctuated from a low of 158 to a high of 169. The average number of beds over the year was 163.

To summarize:

Extended Care Beds approved and staffed

As of:

April, 1981	1,515
December, 1981 (22 new and 33 reopened) 55	55
	1,570
Spring, 1983 + 61 new Extended Care beds	61
Total	1,631

In 1980-81, there were 421 placements made to these beds through the Assessment and Placement Service of Hamilton-Wentworth. For the same time period, the area statistical reports of the Ontario Extended Care Programme reports 516 admissions to the 1,515 beds. Assessment and Placement Service data, then, accounted for 81.6% of these admissions. The remaining admissions are largely made up of patient transfers from residential to extended care within homes for the aged.

Accessibility - Extended Care:

It is important not only to know the number of beds in the Region, but also to examine their distribution and availability to all segments of the population in need.

Geographically, the beds are concentrated in the City of Hamilton, where 74.8% of the extended care beds and 80.6% of the elderly population were located in 1980-81. Stoney Creek, with 5.7% of the elderly population, had 5.6% of the extended care beds and Dundas, with 5.8% of the elderly population, had 7.5% of the extended care beds (see Table 6). With the addition of 55 beds in 1981-82 and 61 beds in 1983-84, the distribution of extended care beds will change to 79.8% in Hamilton, 13.5% in Stoney Creek, and 6.7% in Dundas. The location of the individual is considered in the placement process, in an attempt to minimize travel times for those persons expected to be visiting the individual.

There are currently no extended care beds located in Flamborough,

Ancaster or Glanbrook. While the populations of these areas may not be large enough to support a nursing home of viable size, their growth should be monitored for the possible location of future beds.

Ministry Bed Formula - Extended Care:

The minimum guideline for extended care beds suggested by the Ministry of Health is 3.5 beds per 1,000 resident population. Recognizing that the majority of, but not all, extended care beds are utilized by the elderly, the Ministry has provided age weighting factors to adapt the guideline to the demographic structure of the local Region. The age weighting factors are used in the calculations to arrive at the Ministry minimum guideline for Hamilton-Wentworth for the years 1981 to 1986 (see Figure 3).

In 1980-81, there were 1,515 extended care beds in the Region, which was 46 beds short of the Ministry minimum guideline for 1981. It is noted, however, that the proportion of elderly recorded in 1980 (11.1%) was higher than that projected for the Region by Treasury and Economics figures for 1981 (10.8%) and used in these calculations (see Tables 2 and 3). This has the effect of underestimating the bed requirements calculated by this guideline.

Waiting Lists - Extended Care:

In Hamilton-Wentworth, persons who require long term care are assessed by their family physician and by a visiting nurse (Public Health Nurses, Victorian Order of Nurses, St. Elizabeth Nurses) who see them in their home. If the patient is in an acute care hospital, the assessment is completed by the attending or family physician and the hospital nurse/social work team. This assessment which includes a recommendation for placement utilizes a standard Assessment and Placement Service referral form providing an opportunity for consistent reporting and evaluation. The assessment is then passed to the Assessment and Placement Service where the needs of the patient, as assessed by health care professionals, are matched with the appropriate facility and placement occurs when an appropriate vacancy

Figure 3

MINISTRY MINIMUM GUIDELINE FOR EXTENDED CARE BEDS

Ministry guideline = (% population ≥ age 65) x (age weight factor)
+ (% population < age 65) x (age weight factor)

1981 = $(10.8\%)^{1}$ x $(33.1068)^{2}$ + $(89.2\%)^{1}$ x $(0.243)^{2}$
= 3.80 beds/1,000 resident population
= 3.80 x 423.784^{1}
= 1,610 beds

1986 = $(11.8\%)^{1}$ x $(30.682)^{2}$ + $(88.2\%)^{1}$ x $(0.226)^{2}$
= 3.82 beds/1,000 resident population
= 3.82 x 436.027^{1}
= 1,666 beds

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[1]-Ministry of Treasury and Economics

[2]-Ministry of Health, Data Development and Evaluation Branch

becomes available. Assessment and Placement Service has considerable data on those awaiting placement in the Region, which is examined below.

Based on an analysis of the numbers waiting for placement to extended care beds in the Region through Assessment and Placement Service in 1979-80, the Interim Report of the Long Term Care Task Force recommended an immediate need for an additional 329 extended care beds. Further analysis of the waiting list from January 1977 to August 1981 has shown some variation in the average numbers waiting, with the figure of 329 representing a peak over this time period. For example, the average number on the waiting list dropped from 329 in 1979-80 to 263 in 1980-81. This indicates that the size of the waiting list, subject as it is to fluctuation, should not be used by itself as an indicator of the need for new extended care beds.

The average length of wait between the time the patient is ready for discharge and placement to extended care beds in the Region was calculated for 1978-79, 1979-80 and 1980-81, from the Assessment and Placement Service data (see Table 10). While the number of placements have risen over the three year period, the average length of wait has fluctuated, rising from 108.7 days in 1978-79 to 132.3 days in 1979-80 and falling again to 89.6 days in 1980-81. To examine Hamilton-Wentworth lengths of wait for extended care relative to that in other parts of the Province, data for the Placement and Support Service (P.A.S.S.) Information System was reviewed, as this system provides the only readily available data for this comparison.

During the same three year period, the average length of wait for placement to extended care beds in those areas of the Province participating in the Placement and Support Services Information System has risen from 54.5 days in 1978-79 to 58.0 days in 1979-80 and 61.1 days in 1980-81.[1] In 1980-81, then, the average length of wait in Hamilton-Wentworth was 28.5 days longer than the Placement and Support Service average. The following calculation shows the number of new beds required to lower Hamilton-Wentworth's average length of wait to more closely approximate the Placement and Support

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[1]-Placement and Support Services (P.A.S.S.) Information System, Table 8/1, "Delays in Placement by Actual Placement Accommodation".

Service average:

(a) There were 421[1] placements to extended care beds in Hamilton-Wentworth in 1980-81. With an average length of wait of 89.6 days, this represented 37,722 patient-days waiting (421 x 89.6 = 37,722). To reduce the average length of wait in Hamilton-Wentworth to the Placement and Support Services average of 61.1, then 618 placements would have to have been made with the same number of patient days waiting (37,722 ÷ 61.1 = 617.4).

(b) The turnover rate for extended care beds in Hamilton-Wentworth in 1980-81 is calculated as the number of admissions to extended care beds divided by the number of extended care beds:

$$\text{turnover rate} = 516^{2}/1{,}515$$
$$= .34$$

(c) The number of new beds required can be calculated using the following formula:

(new beds + existing beds) x turnover rate = projected number of placements

$$(x + 1{,}515).34 = 618$$
$$.34x = 618 - 515$$
$$x = 103/.34$$
$$x = 303$$

The calculation indicates that 303 new extended care beds would be required to reduce the average length of wait for placement to extended care beds from 89.6 days to the Placement and Support Services average 61.1 days.

[1]-Assessment and Placement Service data, 1980-81.

[2]-Ontario Extended Care Programme, Area Statistical Report, April 1980 to September 1980, page no. 471; October 1980 to March 1981, page no. 468.

Of this figure 83 beds have been approved and will be in operation by 1983-84 and 33 beds previously licenced have been brought back into operation in December 1981. This then leaves a difference of 187 (303 - 116 = 187) beds, which represents the number of extended care beds that must be phased into the system to reduce the average length of wait.

While the waiting list will drop considerably when new beds are brought on stream, experience shows that the list will build back up again in subsequent years. The impact of these new beds will be monitored after their introduction to the system, with the expectation that further beds will be required by 1984-85.

An analysis of the waiting list data shows that of the 421 people placed in extended care beds in the Region in 1980-81, 158 people (37.5%) waited in an acute bed in a public general hospital.[1] With an average length of wait for these 158 placements of 90.2 days, this represents 14,258 patient days spent in acute beds, or 37.8% of all patient days waiting for this type of care.

In an article examining the use of acute beds by the elderly in Manitoba, Shapiro and Roos (1981) note that the number of long term care patients waiting in acute beds generally has been the cause of much concern to physicians and hospital administrators who may view these beds as being "blocked" to new admissions; and to governments whose concern is over the cost of care to those patients who could be cared for elsewhere. In addition, the patient may experience mental and physical deterioration resulting from a lengthy wait in a hospital bed and may also be viewed with negative attitudes by hospital staff.

In another study, such "blocking" of beds has been attributed to a lack of coordination between acute and long term care institutions, limitations of home care policies, inadequate discharge planning, and a shortage of long term care beds (Hospital Council of Metropolitan Toronto,

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[1]-Assessment and Placement Service data, 1980-81

1974). In Hamilton-Wentworth, the Assessment and Placement Service assures coordinated and planned placements and the Home Care Programme has been operating both an acute and chronic component for several years. This suggests that, of the problems mentioned in the Hospital Council of Metropolitan Toronto Study (H.C.M.T.) study, the only one that applies to Hamilton-Wentworth is the shortage of long term care beds.

Summation - Extended Care:

Currently in Hamilton-Wentworth there are 1,515 extended care beds and this number will increase to 1,631 in 1983. In 1980-81 the Assessment and Placement Service placed 421 people into extended care beds, representing 81.6% of all placements to Extended Care beds in that year. Assessment and Placement Service recorded an average of 263 people waiting for placement to extended care beds in 1980-81. The average length of wait was 89.6 days and 37.8% of the people placed through Assessment and Placement Service waited in acute beds.

With the addition of 55 extended care beds in 1981-82, the Hamilton-Wentworth region will be 40 beds under the Ministry minimum guidelines for 1981. If the average waiting time for extended care beds is to be gradually reduced to more closely approximate the provincial average determined by those municipalities participating in the Placement and Support Service Information System, 187 extended care beds need to be phased in to the complement of 1,631. This condition presents the Health Council with the opportunity to monitor the effect on the system in Hamilton-Wentworth of the addition of 83 extended care beds, and at the end of a year to evaluate any changes that may have occurred in waiting times and waiting lists, both locally and in the Placement and Support Service System.

With the projected increases in the number of elderly, both in absolute numbers and in percentage of the total population, there is no doubt that Hamilton-Wentworth will need additional extended care beds by 1986, and that the figure of 187 is conservative; nevertheless, this number will be evaluated based on the impact on the system of the 83 beds coming on stream between 1981 and 1983. It is felt that 9-12 months is necessary for the

system to reach a steady state after the addition of large numbers of new beds.

Recommendation 9:

> The Task Force recommends that 187 extended care beds be approved to be phased into the Hamilton-Wentworth extended care system between 1983 and 1986 to bring the total extended care beds to 1,818.

3. Chronic Care

Definition:

Chronic care refers to the care required by a person who is chronically ill and/or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable, whose potential for rehabilitation may be limited, and who requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years. (Ontario Ministry of Health, 1975).

Inventory - Chronic Care:

From April to September of 1980, there were 393 chronic care beds in the Region, 284 of which were at St. Peter's Centre, 75 at Chedoke Division and 34 at the McMaster Division of Chedoke-McMaster Hospital. In October 1980, the number of beds at the McMaster Division was increased by 35, bringing the Regional total to 428, the level at which it remained for the rest of 1980-81. Thirty-five of the beds at McMaster Division were moved to the Chedoke Division in January 1981 and another 10 special chronic beds for younger adults were opened at Chedoke in April 1981. An additional 30 beds came into operation at St. Joseph's Hospital in August 1981 making the total chronic care beds 468. Sixty more chronic beds have been approved by the Minister of Health, but are not yet on stream.

From April 1980 to September 1980, then, there were 393 chronic beds in the Region; from October 1980 to March 1981, there were 428. During this time period, 225 placements were made to these beds through the Assessment and Placement Service.

Accessibility - Chronic Care:

All of the above locations which provide the Region's chronic beds are in the City of Hamilton and are available to all segments of the long term care population.

Interim Report:

The following briefly describes the Interim Report analysis of the need for new chronic care beds. Three factors which influenced this analysis and which continue to exist are:

(1) The assessment of patients for institutional chronic care in Hamilton-Wentworth is a very complete and accurate procedure. The assessment carried out by the attending physician is considered carefully by the Assessment and Placement Service and by the receiving institution. As a result of the guidelines which are applied to chronic care cases in this district, it is felt that all patients who are recommended for institutional chronic care do indeed require such care.

(2) In addition to this, although no hard data exists, the Task Force, having received and considered the briefs from the care providers, concluded that very few of these chronic cases could be properly cared for in settings other than the chronic care institutions in an economically feasible way. Given that chronic care is reserved for only those patients requiring heavy care or specialized services it is felt by the Task Force that to support these patients appropriately in another setting would cost more in special nursing and support services than the approximate per diem cost of $85 for chronic patients who are in a chronic care institution.

(3) Since Assessment and Placement Service receives the referrals for all cases, its records constitute a complete account of the chronic care patient flow.

In Hamilton-Wentworth, the caseload of the chronic care institutions can be divided into two distinct age categories. For the most part, St. Peter's Centre and Chedoke-McMaster Hospitals serve the chronic care needs of the geriatric population with the Chedoke Continuing Care Centre at the Chedoke

Division of Chedoke-McMaster Hospital serving the non-geriatric chronic patient. For this reason, the analysis of need was conducted separately on both of these categories.

As a result of these factors which made and continue to make the chronic care system and the statistics available on it a complete entity, the Task Force developed a methodology to determine the number of beds required in the system to have the inflow of patients onto the waiting list (which is signified by the number of patients recommended for placement minus those who withdraw for reasons other than death) equal the number of patients leaving the waiting list (which is signified by the number of placements).

The records of the Assessment and Placement Service indicated that in 1979-80 a much greater number of people were recommended for placement in a chronic care bed than the number of people who were placed in a chronic bed. This discrepancy resulted in a growing accumulation of patients on the waiting list, with the majority of these cases obstructing the utilization of beds in other levels of care, i.e. the turnover rate of patients occupying beds was not great enough to allow the flow of newly assessed patients to equal the flow of patients exiting the system. Stated another way, given the turnover rate, there were not enough chronic care beds to allow the number of patients entering the system to equal the number of people exiting the chronic care beds. Therefore, a formula was developed to establish the number of beds required to have these two factors equal one another.

It is important to note that the number being recommended for placement was adjusted to account for persons withdrawing from the system. Withdrawal may be caused by a change in the patient's condition, a change in the patient's or the family's willingness to be placed and refusal of the patient by the recommended institution. An adjustment was also made for persons who were recommended for placement but who died within two weeks of the recommendation being made. It is felt that even with the system in balance, processing of applications and placement of these patients would take

approximately two weeks, thus reducing the number of beds required to accommodate all recommendations.

Given the above conditions, the formula described below was used to determine the number of beds required to have the number of patients entering the chronic care system equal the number leaving it:

Number of recommendations - (waiting list withdrawals for reasons other than death + deaths within two weeks of recommendation)

= Present Rate of Turnover (Present Number of Beds + Additional Beds required)

(a) Elderly:

Assessment and Placement Service records showed that during the period from April 1, 1979 to March 31, 1980 there were 361 recommendations for placement to chronic care at St. Peter's Centre or McMaster Division of the Chedoke-McMaster Hospital.

Seventy-six recommendations were removed from the list for reasons other than death. Of these, 16 withdrew their request for placement, 35 had a change of condition, 12 were placed in other facilities, and 13 were refused acceptance by the suggested institutions because their care requirements were greater than those available in either chronic care facility. In addition, 60 persons died within one month of being recommended for placement in a chronic care bed. Therefore, it was assumed that 30 of these patients would have died in the initial two weeks following the recommendations and an adjustment to the number of recommendations is made to reflect the fact that a chronic care bed would not have been required for these patients. This left 255 recommendations.

In the same period only 144 patients were placed indicating a significant difference of 111 between the number of cases going on to the waiting list and the number of cases coming off the waiting list.

Given that 144 placements were made into the 318 existing beds, the turnover rate for these beds was 45%.

$$144/318 \times 100 = 45\%$$

Using the algebraic formula whereby we know the number of patients placed on the waiting list (255), the rate at which patients vacate the present beds (45%), and the number of beds in the system (318), the number of beds (x) that will be needed to balance the flow of patients into the system with the flow of patients out of the system was calculated as follows:

$$(318 + x).45 = 255$$
$$143 + .45x = 255$$
$$.45x = 255 - 143$$
$$x = 249$$

The Interim Report therefore recommended that Hamilton-Wentworth would need 249 more beds for this care group for the number of patients being recommended for care to equal the number of beds being vacated.

(b) Non-Elderly:

During the period April 1, 1979 to March 31, 1980, there were 41 recommendations for placement to the Chedoke Continuing Care Centre of Chedoke-McMaster Hospital, 17 of which were removed prior to placement for reasons other than death, i.e., nine patients withdrew their applications, five patients were placed in other facilities and three patient's applications were refused because a suitable programme was not available, leaving a net total of 24 recommendations. Death while awaiting placement was not a significant factor with this care group.

Given that 21 placements were made into the existing 93 beds, the turnover rate for these units was 23%. Using the same formula as before, the Task Force determined the number of additional beds required to close the gap between recommendations and placements:

$$(93 + x).23 = 24$$
$$21 + .23x = 24$$
$$.23x = 24 - 21$$
$$x = 13 \text{ beds}$$

Therefore, it was determined that Hamilton-Wentworth would require 13 more beds for this care group for the number of patients being recommended for this type of care to equal the number of beds being vacated. Therefore, total additional requirements for both categories of chronic care beds recommended in the Interim Report were 249 + 13 = 262 beds.

The Report noted that the 262 beds identified by this analysis were not an expression of the need for chronic care beds at that time, but were the number of beds required if the chronic care system were to have the capacity to care for all patients being referred to it. The immediate addition of chronic care beds to accommodate the average number of patients on the Assessment and Placement Service waiting list for the previous year was recommended to alleviate the then critical shortage of beds. The waiting list for chronic care patients averaged 135 persons from April 1, 1979 to March 31, 1980, indicating that this was the number of chronic care beds required to temporarily eliminate the backlog of patients in the system (75 beds had already been approved by the Minister of Health but were not in operation at the time of this analysis).

The Task Force also emphasized that a staged programme of adding 262 beds over the next four to five years was required. It was suggested that following the immediate addition of 135 chronic care beds, further additions should await the development of a long range plan by this Task Force to accommodate the beds presently in temporary locations in the district, plus the additional beds which will be required by 1984-85, to be carried out in conjunction with the planning of the redevelopment of the Chedoke Division of Chedoke-McMaster Hospital.

Recognizing that 75 of the 135 beds had already been approved, the Interim Report requested a further 60 chronic care beds immediately, and a further 127 beds by 1984-85.

In a letter dated May 8, 1981, the Minister of Health approved in principle the 60 beds, and requested that the further 127 be considered in conjunction with the redevelopment of the Chedoke Division of the Chedoke-McMaster Hospital.

Ministry Bed Formula - Chronic Care:

The Ministry minimum guideline for the provision of chronic care beds is 11.9 beds/1,000 referral population ≥ age 65.[1] Guidelines for 1981 and 1986 are as follows:

1981: $11.9 \times 48.928^{2} = 583$

1986: $11.9 \times 54.878^{2} = 653$

These calculations are based on population projections, but are only available as far as 1986. A simple projection of the 1986 figure reveals a figure in the order of 58.691 for 1990.

1990: $11.9 \times 58.691 = 699$ beds

Waiting List - Chronic Care:

All applicants requesting admission to chronic care units in Hamilton-Wentworth are assessed by their own health care professionals using the Assessment and Placement Service standardized referral form for consistent identification of care needs. Applications are reviewed by intake committees for each facility, and each individual is assigned to an appropriate care category. i.e., confused ambulant, reactivation, maintenance, major medical/life support.

Monthly reports of the Assessment and Placement Service show an average of 135 persons awaited institutional placement at the chronic level during 1979-80. Thirty-five beds came on stream in 1980-81 and the average waiting list for chronic care beds in this year was 103, down only 32 from that reported in the Interim Report. Another 40 beds have come on stream in the first six months of 1981-82 and the average waiting list for this time period was 88. While the immediate effect of adding these beds has been to

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[1]-currently under review

[2]-Ministry of Health, Data Development and Evaluation Branch

reduce the waiting list, without the addition of further beds the list will soon rise again. As mentioned in the section on extended care, the number on the waiting list is subject to fluctuation and should not be used alone as a measure of need.

To further support the figures recommended in the Interim Report, average lengths of wait are examined. The average length of wait between the time the patient was ready for discharge and placement to chronic care beds in the Region was calculated for 1978-79, 1979-80 and 1980-81, from Assessment and Placement Service data (see Table 10). While the number of placements have risen over the three year period, the average length of wait has fluctuated, dropping from 147.7 days in 1978-79 to 129.8 days in 1979-80 and remaining at 128.8 days in 1980-81. To examine the Hamilton-Wentworth lengths of wait for chronic care relative to that in other parts of the Province, data from the Placement and Support Service Information System was reviewed, as this system provides the only readily available data for this comparison.

During the same three year period, the average length of wait for placement to chronic care beds in those areas of the Province participating in the Placement and Support Service Information System has risen from 21.7 days in 1978-79 to 37.6 days in 1979-80 and to 45.6 days in 1980-81.[1]

In 1980-81, then, the average length of wait in Hamilton-Wentworth was almost three times longer than the Placement and Support Service average. The following calculation shows the number of new beds required to bring Hamilton-Wentworth's average length of wait in line with the Placement and Support Service average:

(a) There were 225[2] placements to chronic care beds in Hamilton-

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[1]-Placement and Support Service Information System, Table 8/1, "Delays in Placement by Actual Placement Accommodation"

[2]-Assessment and Placement data, 1980-81

Wentworth in 1980-81. With an average length of wait of 128.8 days, this represents 28,986 patient days waiting. If the average length of wait had been equal to the Placement and Support Service average of 45.6 days, then 636 placements could have been made with the same number of patient days waiting ($28986 \div 45.6 = 636$).

(b) The turnover rate for chronic care beds in Hamilton-Wentworth in 1980-81 is calculated as the number of discharges and deaths from chronic care beds divided by the average number of chronic care beds.

$$\text{turnover rate} = 358^{1}/411^{2}$$
$$= .87$$

(c) The number of new beds required can be calculated using the following formula:

(new beds + existing beds) x turnover rate = projected number of placements

$$(x + 411).87 = 636$$
$$.87x = 636 - 358$$
$$x = 278/.87$$
$$x = 320$$
$$320 + 411 = 731$$

This calculation indicates that 320 new chronic care beds are required to reduce the average length of wait for chronic care beds from 128.8 days to the Placement and Support Service average of 45.6 days. This would

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[1]-Data Development and Evaulation Branch, Ministry of Health

[2]-Chronic care beds April 1980 to September 1980 = 393; October 1980 to March 1981 = 428; Average number of beds = 410.5; rounding up = 411 beds

bring the Regional total of chronic care beds from its present level of 528 beds on stream or approved, to 731 beds (320 + 411). This is 76 beds more than that recommended by the Interim Report for 1984-85, and is the number of beds required for 1990-91.

An analysis of the waiting list data shows that of the 225 people placed in chronic care beds in the Region in 1980-81, 121 people (53.8%) waited in an acute bed in a general hospital.[1] With an average length of wait for these 121 placements of 149.7 days, this represents 18,117 patient days spent in acute beds, or 62.5% of all patient days waiting for this type of care. In 1979-80, 96 of the 168 people placed in chronic care beds (57.1%) waited in an acute bed.

As was indicated in the extended care section, there is considerable concern over the number of long term care patients waiting in acute beds, relating to the questions of "blocked" beds, costs, and patient welfare. A study by the Hospital Council of Metropolitan Toronto (1974) attributed such blocking of beds to a lack of coordination between acute and long term care institutions, limitations of home care policies, inadequate discharge planning, and a shortage of long term care beds. In Hamilton-Wentworth, the Assessment and Placement Service assures coordinated and planned placements, and the Home Care Programme has been operating both an acute and chronic component for several years. This suggests that, of the problems mentioned in the Hospital Council of Metropolitan Toronto study, the only one that applies to Hamilton-Wentworth is the shortage of long term care beds.

Summation - Chronic Care:

The long term support needs created by the increase in the numbers of aging population in Hamilton-Wentworth and across the country have been recognized as both an immediate and long term requirement of our system. Over the past few years this District has been able to study and develop long term care support services and methods of appropriate placement into

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[1] -Assessment and Placement data, 1980-81

such services. The greater awareness of the need for such long term support has developed simultaneously with new and heavier demands created by larger numbers and accentuated by constraints placed on the acute care health system. The Task Force and the institutions and service agencies have identified the requirements to cope with the immediate and long term demands and shortages of chronic care beds and support facilities.

The Task Force supports the statement of the Institutional Chronic Care Task Force of the Health Council that an integrated chronic care programme for the district is required, with a maximum utilization of existing resources and services and the identification of additional resources required.

This programme will result in the addition of another major chronic care institution with identified philosophy, administrative and professional organization, and a small specialty unit attached to a general hospital where life support systems are required.

The emphasis of St. Peter's Centre will continue to be a community support, functional reactivation, special management and control and flexible programming for geriatric patients.

The Chedoke Division of Chedoke-McMaster will provide specific medical support, assessment unit support, psychiatric support and an educational presence, plus community support, functional reactivation, special management and control and flexible programming for children and adults.

A thirty bed unit at St. Joseph's Hospital provides major medical/ life support management and maintenance in primarily dialysis and respiratory problems.

At the time of the Task Force's Interim Report, there were 393 chronic care beds on stream, and a further 76 had been approved by the Minister. At that time the average number of people waiting for placement to chronic care through Assessment and Placement Service was 135, the average length of wait was approximately 130 days, and 57% of the people placed through Assessment and Placement Service waited in acute beds. The Interim Report recommended the immediate addition of 60 beds (in addition to the 75 already approved)

and a further 127 beds by 1985. In May, 1981, the Minister approved in principle the addition of 60 beds and requested that the 127 beds be planned in conjunction with the proposed redevelopment of the Chedoke Division of Chedoke-McMaster Hospital. The addition of these beds would bring the Regional total of chronic beds to 528 immediately, and to 655 by 1985.

In October 1980, 35 of the 75 beds came on stream, and their effect was felt in 1980-81. In that year, the Assessment and Placement Service placed 225 people into these beds, or 56 more than in 1979-80. Assessment and Placement Service recorded an average of 103 people waiting for placement to chronic care beds in 1980-81 (32 less than the previous year), but the average length of wait for placement did not change appreciably.

A comparative analysis of the average length of wait for placement in Hamilton-Wentworth in 1980-81 with that of all other areas of the Province participating in the Placement and Support Service Information System indicates that 76 chronic care beds, beyond the number recommended in the Interim Report, are required to reduce the average length of wait in Hamilton-Wentworth to more closely approximate that of the Placement and Support Service Information System. This would bring the Regional total to 731 beds, and the new beds would be phased in concurrent with the rebuilding of Chedoke Division of Chedoke-McMaster Hospital. The Ministry of Health minimum guideline for chronic care beds identifies minimum bed requirements for this Region of 583 in 1981 and 653 in 1986. This guideline is based on referral population projections which are not available beyond 1986. These figures lend support to those recommended in the Interim Report, requiring that additional beds be phased in over the next several years, with a long range goal of 731 chronic beds by 1990-91.

In addition, the Task Force notes that 20 rehabilitation beds located at the Chedoke Division of the Chedoke-McMaster Hospital are currently being used as chronic care beds. Ministry guidelines indicate that Hamilton-Wentworth is already under-supplied in rehabilitation beds, which demonstrates

that these beds should return to their intended function, thereby creating a further need for chronic care beds. Also, as discussed in the Section on Chronic Life Support of this Report, 8 chronic care beds are required for this service.

The Task Force is cognizant of the Minister's desire to have further bed requirements planned in conjunction with the redevelopment of the Chedoke Division and therefore recommends that the Chedoke Division be rebuilt to include among other programmes, 342 chronic care beds.

Planning should also proceed for the addition of 75 more chronic care beds by 1990 based on the effects these chronic beds have on the district integrated programme, on waiting lists and lengths of wait in conjunction with population trends.

In addressing the present short term need for additional beds, the Minister approved 60 beds in May 1981. At this time, however, the availability of beds and space will dictate the location of these beds. The Task Force recommends that the immediate addition of these beds take place where facilities exist until the facilities at Chedoke Division are re-built. At its November 1981 meeting, Health Council recommended to the Minister that 30 general maintenance beds and 8 life support beds be located temporarily in space available at Henderson General Hospital.

Recommendation 10:

The Task Force recommends that the total number of chronic care beds in the Region be 731 by 1990-91, to be distributed as follows:

-St. Peter's Centre	284		-current # beds
-St. Joseph's Hospital	30		-current # beds
-Chedoke Division of	417:	120	-current # beds
Chedoke-McMaster		35	-from McMaster Division
Hospital		60	-approved May, 1981
		127	-additional beds required, 1986
		75	-additional beds required, 1990
		417	
	731		

and further, that, of the 60 beds approved in May, 1981, 38 be temporarily located at Henderson General Hospital awaiting the redevelopment of the Chedoke Division of Chedoke-McMaster Hospital, consisting of:

30 - general maintenance beds
8 - life support beds
38

4. Other Institutional Care

4.1 Extended Care for the Non-Elderly:

Definition:

Extended health care (as defined above) provided to persons who are under age 65 (Long Term Care Task Force).

Background:

This population group represents the non-elderly segment of the extended care population discussed above. The Assessment and Placement Service has made a number of placements to nursing homes and homes for the aged of this group in recent years, but has also noted a large number of cases where the individual refused placement in a nursing home. The concern for this group centres on their social needs and the potentially deleterious effect of spending many years without others of their own age to relate to.

Inventory - Extended Care for the Non-Elderly:

Table 20 shows the number of young extended care placements in Hamilton-Wentworth over the past three years. The average number of such placements over the past three years is 28 per year, and these placements represent 7.1% of all placements made to extended care beds in the three year period.

As of February 1981, there were 90 nursing home patients in Hamilton-Wentworth under the age of 60. These 90 were located in 17 different nursing homes and the largest number in any one home was 18. Table 20 shows that the number of placements of people under this age has been steady at 16 or 17 for the past three years.

Summation - Extended Care for the Non-Elderly:

The non-elderly segment of the extended care population currently occupies approximately 6% of the extended care beds in the Region and has accounted for approximately 6% of Assessment and Placement Service placements to those beds in the past three years (see Table 20). Because of their age,

Table 20

Age of Placements to Extended Health Care
in Hamilton-Wentworth,
1978-79, 1979-80, 1980-81

	1978-79	1979-80	1980-81
Under 50	5	4	6
50-59	12	12	11
60-64	14	6	12
Total under Age 65	31	22	29
(% Total of All Ages)	(8.7%)	(5.9%)	(6.2%)
Total All Ages	356	370	421

Source: Assessment and Placement Service data

placement in a nursing home may leave the psycho-social needs of this group unmet. In addition, the Administrator of Assessment and Placement Service has noted that many in this category refuse placement to a nursing home, thus creating difficulty for Assessment and Placement Service staff in securing placements to a treatment setting in which their needs will be met.

Recommendation 10:

> The Task Force recommends that the Health Council, in conjunction with the Assessment and Placement Service, undertake further study of the need for developing appropriate programmes/facilities for extended care patients under age 65.

4.2 Institutional Respite Care

Definition:

Institutional respite care refers to temporary alternative arrangements for a client to allow the usual supervising and/or assisting person a vacation or relief from care of the client, or to provide short term care where the usual caregiver is temporarily unable to provide care. Institutional respite care is provided at a different residential or health setting than the client's home setting (Long Term Care Task Force).

Background:

The goal of Institutional respite care is to enable the caregiver to continue care of the patient in the community as long as possible. This is accomplished by allowing the family or usual caregiver the opportunity of extended relief from giving care, or by providing care when the usual caregiver is temporarily incapacitated or unable to give care due to a short term crisis situation. Without this opportunity, the family may not be able to cope with the provision of continuous care, or there may not be anyone who can provide care, resulting in an institutionalization that is inappropriate. Respite periods are usually for two to four weeks, though

may be as short as a weekend and as long as six weeks.

Inventory - Institutional Respite Care:

Institutional respite care has been available in small measure in the chronic care facilities in Hamilton-Wentworth for a number of years, although beds were not specifically devoted to this purpose, nor was it generally acknowledged as a practice. Since 1979, however, all chronic care facilities provide this type of family assistance. In addition, homes for the aged have provided vacation periods of up to one month in the normal care section. An attempt is made to improve the quality of life for each patient through activation and rehabilitation, rather than providing simply a guardian service. Nursing homes in this area have not been able to develop similar programmes, meaning that extended care patients must enter a chronic care facility for respite care.

There is a constant demand for institutional respite beds for vacation purposes directed at the Assessment and Placement Service and, while no beds are designated for this type of care, most requests are met when a two month advance notice is given. In 1980-81 the Assessment and Placement Service coordinated the placement of 42 persons in chronic care facilities and four people in homes for the aged, for institutional respite care.

A type of institutional respite is provided by the day programmes in long term care in the Region. In these cases short term relief from care is provided to the usual caregiver by allowing the patient to attend the day programme.

Summation - Institutional Respite Care:

The importance of institutional respite care and its potential to prevent permanent institutionalization is recognized by those facilities which offer it and, hence, efforts are made to be flexible in offering this type of care. It is very difficult to assess the real need for this type of care, other than to identify the current utilization. Assessment and Placement Service notes that all requests for this type of care in the

past year have been met. Having a broader range of facilities, including nursing homes and more homes for the aged, where respite care is provided would seem to be advantageous in providing this important service, and the Task Force supports the efforts of the Assessment and Placement Service in monitoring the provision of this service.

4.3 Chronic Life Support

Definition:

Persons who can be classified as in need of chronic care but who require specific skilled services not generally available in chronic care facilities, such as life support mechanisms and/or extensive nursing care (Long Term Care Task Force).

Background:

The Assessment and Placement Service, in cooperation with chronic and acute care facilities, has identified a small sub-group of the chronic care population that requires intensive skilled service. These individuals have a physical disability of at least one organ to the level that artificial support is required to maintain viability. In addition, they may require active technical therapy, 24-hour monitoring of body functions and other extensive nursing services (Institutional Chronic Care Task Force, 1980).

This group is generally cared for in an acute setting despite its long term chronic nature, as the services required are either not normally available in chronic care facilities or are greatly in excess of normal staffing patterns.

Inventory - Chronic Life Support:

From October 1980 to September 1981, Assessment and Placement Service recorded an average of four persons at any one time for whom this type of care was required, with a maximum of eight at any one time. These patients have been maintained in active treatment beds in acute care hospitals, as there are currently no beds designated for chronic life

support. The majority of life support patients have been brain damaged due to accidents and, currently most are maintained in the neurological services wards of the Hamilton General Hospital. It is anticipated that modern methods of medical intervention will cause the number in the sub-group to increase.

Summation - Chronic Life Support:

This sub-group of the chronic care population requires expensive life support mechanisms or extensive nursing services and generally occupies acute beds. Currently there are no beds designated for this purpose and these patients must occupy acute beds designated for other purposes.

Recommendation 12:

> The Task Force recommends that, together with the 30 general maintenance chronic beds being recommended for temporary location at the Henderson General Hospital, 8 beds designated for chronic life support be set up at the same location.

The Task Force is assured that the provision of these eight chronic life support beds and thirty general chronic beds on a temporary basis, pending the redevelopment of the Chedoke Divison of the Chedoke-McMaster Hospital, is acceptable to the administration of the Civic Hospitals and to others involved in the provision of chronic care in the Region.

4.4 Physically Disabled and Profoundly Mentally Retarded Young Adults

Definition:

Persons who can be classified as being in need of long term chronic care (as defined above) who suffer from both severe physical disabilities and severe developmental handicaps and who are over age 18 (Long Term Care Task Force).

Inventory - Physically Disabled and Profoundly Mentally Retarded Young Adults

The Rygiel Home in Hamilton provides a residence for physically and developmentally handicapped children under the age of 18, funded by the Ministry of Community and Social Services. Rygiel's programme emphasis is on developmental handicaps and the ultimate integration of the mentally retarded person into the social community. The Home is approved for 101 beds and, currently, there are 53 residents over age 18, and another 10 who will soon be 18. Of these, 20 have been referred for chronic care placement to Assessment and Placement Service, which has been unable to place them. As they continue to occupy beds in the Home, they block the admission of other severely disabled children.

Summation - Physically Disabled and Profoundly Mentally Retarded Young Adults:

This clearly indentifiable sub-group of the chronic care population is currently inappropriately placed. This inappropriate placement means that only the basic needs of this group are being met.

Responsibility for programmes for the mentally retarded belongs to the Ministry of Community and Social Services; however, because of their severe physical disabilities these young adults may require services normally available through programmes supported by the Ministry of Health. At this time, neither Ministry appears to have addressed the problem of the multi-handicapped young adults, despite inter-Ministerial dialogue on this issue. The question of Ministerial responsibility in this specific case should be examined by the Ministry of Health and the Ministry of Community and Social Services, and appropriate action taken.

Recommendation 13:

> The Task Force recommends that the Health Council initiate discussions through the Ministry of Health, with the Ministry of Community and Social

Services (COMSOC) and the Rygiel Home, with a view to resolving the issue of appropriate placement for those residents of this home over age 18 who are both physically disabled and profoundly mentally retarded.

4.5 Confused Ambulant

Definition:

For this Report, persons with cognitive dysfunctions or impairments of whatever cause whose condition may have been labelled "senile", "demented" or other similar generalizations, as well as patients whose cognitive impairments have been investigated and diagnosed in greater detail, have been grouped under the general heading of "confused". The general characteristics of persons in this group are gross impairment in judgement and either a total or intermittent inability to comprehend their life situation. "Ambulant" in this grouping refers to a person who is independently mobile either walking unaided, with a cane, crutches, walker, or in a wheelchair (Long Term Care Task Force).

Background:

The confused person, who is unable to comprehend the present life situation, requires someone who will provide him/her with care. While this in itself can be difficult, when the confused person is also ambulant, almost constant supervision is required. Providing this type of care can throw immense burdens on the spouse and family, causing strain and potential breakdown.

At the same time, it is difficult to place confused and ambulatory people in the appropriate setting. The homes for the aged have facilities which protect the resident from wandering away from a special care area and offer programmes designed specifically for this group. Often, however, the waiting period for this accommodation is such that alternative accommodation must be sought. Nursing homes accept many of these people, but few have premises which protect the confused ambulant persons from wandering away,

presenting problems for the staff in maintaining constant supervision. Such problems are also encountered by the staff of day programmes and, hence, this group is often excluded from eligibility for day programming.

The confused and ambulant elderly comprise a portion of the target group for geriatric psychiatry, which refers to the assessment, treatment and management of elderly people suffering from all types of mental disorders. The literature on geriatric psychiatry suggests that at present 20% to 40% of the elderly suffer from psychiatric disorders: 5% to 10% have a form of dementia and 20% to 30% have neurotic, affective or schizophreniform disorders. Further, up to 30% of first mental hospital admissions are of people 65 and over (Cole, et. al., 1981).

While geriatric psychiatry is primarily concerned with acute care, there are implications for long term care in the potential to prevent institutionalization or hospitalization, and in the appropriate placement to the correct category of long term care. For example, in a study carried out in an acute medical geriatric evaluation unit, psychiatric disorders were found far exceeding those expected in a comparable general population and most were not recognized prior to the patient's transfer to the special unit (Cheah and Beard, 1980). In addition, it is estimated that 5% to 10% of dementias in the elderly are potentially reversible, given early diagnosis (Cole, et. al., 1981).

In order for geriatric psychiatry to impact to its full potential on long term care, however, the delivery of services must be comprehensive. A model for a comprehensive geriatric psychiatry service has been suggested, whose components would include:

1. a consultative-outreach team for general hospital wards, nursing homes, long term care patients in their own homes
2. a psychiatry outpatient clinic
3. a psychiatry day hospital
4. a psychiatry inpatient assessment and short term treatment ward.

All of the foregoing would be acute care services, staffed accordingly and with ready access to rapidly available medical, neurological, surgical consultants and extensive laboratory, radiological, neuro-radiological and electro-physiological investigations.

In addition the following would be necessary:

1. medium stay beds
2. liaison between the geriatric psychiatry service and various long-stay residential facilities for the elderly
3. liaison with community workers and support services
4. improved access to long term care facilities.

The success of the entire system would depend on a system of progressive patient care through the various components, dependent on clinical needs. At all stages of the process, team work involving psychiatrists and other physicians, nurses, occupational therapists, social workers, psychologists and community workers would be essential (Roy, 1981).

Inventory - Confused Ambulant:

The Assessment and Placement Service of Hamilton-Wentworth has identified a growing number of confused and ambulant patients and has also identified the general lack of appropriate services and facilities available for them. As Table 21 indicates, however, the number of referrals has increased over the past three years, and some placements have been made, primarily to nursing homes and homes for the aged (extended health care and residential care).

Limited acute geriatric psychiatry services are available at three general hospitals in Hamilton-Wentworth. The Geriatric Psychiatry Assessment and Consultation Service located at the Chedoke Division of Chedoke-McMaster Hospital provides diagnostic assessment. In 1980, this service provided a mental status examination, medical examination, diagnostic formulation and treatment plan for 135 new patients, for a total of 449 patient visits. In the first six months of 1981, 126 new patients were seen, for a total of 490 patient visits. Approximately 35% of these patients were cognitively impaired and self mobile and could be classed as confused

Table 21

Recommendations (Recoms) and Placements (Plcmts) Made Through the Assessment and Placement Service of Confused Ambulant Persons 1978-79, 1979-80, 1980-81

	1978-79		1979-80		1980-81	
	Recoms[1]	Plcmts	Recoms	Plcmts	Recoms	Plcmts
Residential Care		28	24	29	31	22
Extended Care		84	152	79	181	91
Chronic Care		6	17	11	42	17
C.C.C.C.[2]		---	---	---	4	1
St. Peter's Centre Day Therapy		5	6	5	4	3
Home Care Programme		4	1	3	2	7
Other		8	23	11	21	13
Total	240	135	223	138	285	154

[1]-Breakdown of recommendations not available

[2]-Chedoke Continuing Care Centre Day Hospital

Source: Assessment and Placement Service data

ambulant.

The Geriatric Psychiatry Assessment Service is an evolving service with the potential for much greater involvement in the future. It is anticipated that additional staff will be available to serve a larger population than at present, as awareness of the service and subsequent referrals increase. This service also provides consultation to one nursing home on a trial basis, and evaluation of this programme will determine the extent to which it can be offered to the general nursing home community.

A new proposal from St. Peter's Day Therapy Centre would see the expansion of that programme to include the confused ambulant elderly, which would provide the first day programming for this group in the Region (see Day Programming section). Also, recognizing the need for institutional care appropriate to the confused ambulant, 40% of the client population of the Clarion Nursing Home (to be rebuilt at 100 beds in the East End in 1983-84) will be confused ambulant patients, referred through Assessment and Placement Service. The Home will be built with special facilities to meet the needs of this group.

Summation - Confused Ambulant:

In Hamilton-Wentworth, as is the case elsewhere, there exists an identifiable sub-group of the long term care population who, because they are confused and ambulant, require a great deal of care and supervision. Early detection and treatment can potentially result in the reversal of this condition, through the services of geriatric psychiatry. For others, the quality of life may be improved and the level of required care reduced. There will still remain, however, a large portion of this group which will require placement to long term care services with appropriate facilities and programming. The availability of such facilities and programming will be monitored by the Health Council and the Assessment and Placement Service.

Currently in the Region there are limited geriatric psychiatry services, and the extent of their potential impact on institutionalization rates for

this group is not fully known. The Geriatric Psychiatry Assessment and Consultation Service at the Chedoke Division of the Chedoke-McMaster Hospital provides an innovative model for this type of service, which appears to be working for three major reasons. First, the service is tied to a general hospital with excellent diagnostic facilities available; second, patients are seen earlier on an outpatient basis than they would on an inpatient basis; and, third, good cooperation exists between health services in the Region.

Recommendation 14:

> The Task Force recommends that Chedoke-McMaster Hospital, in its feasibility study of the rebuilding of the Chedoke Division, determine the appropriate size and scope of the Geriatric Psychiatry Assessment and Consultation Service to meet District needs.

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Appendix A

INVENTORY OF LONG TERM CARE FACILITIES/SERVICES

FOR THE

HAMILTON-WENTWORTH REGION

See accompanying document under separate cover